Dialectical behaviour therapy: factors relating to dropout and experiences of completion.

Moninne McCormack

Supervised by:

Professor James McGuire

Dr Claire Iveson

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Moninne McCormack

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Appendices

Thesis Overview

This thesis focuses on non-completion of dialectical behaviour therapy (DBT) for people with some features of personality difficulties (FPD) and termination of DBT for people with borderline features (BF). It contains two distinct journal papers; a systematic literature review and an empirical paper.

The findings from the systematic review are outlined in chapter one. The focus of this review is on why participants do not complete DBT programmes for FPD and the characteristics of these participants. The paper begins by briefly describing DBT, FPD and the relationship between FPD and treatment completion including the associated literature and the rationale for the review. The paper then synthesises the findings from the 11 quantitative studies that meet the inclusion criteria. The findings are discussed including the limitations of the studies, reliability and validity of the findings and the strengths and limitations of the review itself along with outlining areas for future research. One of the main limitations is that there is a dearth of qualitative studies exploring non-completion of DBT.

While this systematic review is focused on non-completion of DBT one of the aims of DBT is to reduce dropout rates. There is a lot of research and literature available on the effectiveness of DBT for participants that engage with the programme, however, there is no research on their experiences of successfully completing and terminating the DBT programme. This provides a rationale for the necessity of qualitative studies to explore what this experience was like for participants.

Chapter two is an empirical study exploring participants' experiences of terminating DBT using an Interpretative Phenomenological Analysis approach. To the author’s knowledge, this paper is the first qualitative study to explore the concept of therapy termination of DBT for participants with BF. The aim was to explore participants’ experiences of ending a DBT programme and how this experience has influenced their perception of previous endings and management of future endings. The paper describes the existing literature in relation to termination of therapy, the methodology, procedure and analytic process and the findings. The four main themes that were derived from analysing the interview transcripts from six

participants were; (1) fear arising from the powerful influence of previous experiences of ending, (2) engagement with the therapeutic structure of DBT to manage the ending, (3) experiencing the ending of DBT as a reparative process and (4) personal growth during the DBT programme resulting in a sense of enhanced resilience. The findings were then discussed in relation to the existing literature and the clinical implications of the findings.

Both chapters are written for publication in academic journals so it was not possible to always include sufficient details; therefore information is included in the appendices to supplement the papers.

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Non-completion of dialectical behaviour therapy for features of personality difficulties: a systematic review

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Chapter 1: Systematic Review

Moninne McCormack

Abstract

Engaging and retaining service users in therapy is important for achieving good clinical outcomes. One aim of dialectical behavioural therapy (DBT) is to reduce dropout rates through engagement strategies, however there is an emerging evidence base focused on factors specifically related to non-completion of DBT for features of personality difficulties (FPD). The aim of this review is to summarise the findings from studies that explore what is known about why participants do not complete DBT programmes for FPD and their characteristics. Using a systematic strategy the databases PsycINFO, PubMed, CINAHL, Web of Science, Medline and Scopus were searched for English-language only papers but with no restrictions in relation to date of publication. Papers were selected that included data in relation to dropout of adult participants from DBT for FPD. Eleven papers were included, nine observational studies and two controlled trials. The results are separated into four broad categories; personal characteristics, co-morbidity and distress, environmental and relational factors, and motivation. The results highlight the complexity of factors involved in non-completion of DBT for FPD. Further research using qualitative methods to explore participants' reasons for non-completion is required to fill a gap in the literature.

Key words (MeSH headings): Borderline Personality Disorder; Dialectical Behavioural Therapy; dropout; non-completion; psychological; systematic review

Introduction

Dialectical behaviour therapy (DBT; Linehan, 1993) is an integrative treatment approach that is guided by two components, the biological (dysfunction of the emotional regulation system) and social-environmental (subjective experiences being met with invalidating responses). It was developed specifically for those with a diagnosis of borderline personality disorder (BPD). While the author would rather understand an individual's difficulties in the context of their personal life experiences the terms personality disorder (PD) and BPD will be used throughout this review since they are the classification terms used in the literature. DBT in its original form is a manualised outpatient treatment program comprising four core components; weekly individual therapy, weekly skills training group, telephone coaching and consultation for the therapeutic team (Linehan, 1993) It has been shown to be both effective (Linehan et al., 2002; Linehan et al., 1999) and efficacious (Linehan, 1997). As a result DBT has been recommended as a treatment of choice for BPD by the American Psychiatric Association (APA, 2001), National Institute for Mental Health in England (NIMH(E), 2003) and National Institute for Clinical Excellence (NICE, 2009). Furthermore DBT has now been truncated to six months and labeled Brief DBT (DBT-B; Stanley, Brodsky, Nelson, & Dulit, 2007) and it has also been adapted for inpatient settings (Swenson, Sanderson, Duilt & Linehan, 2001) and as a shorter intensive therapy (I-DBT) for outpatients (McQuillan et al., 2005). I-DBT consists of all the components of DBT but it takes place over three or four weeks with service users receiving approximately 13 hours of group therapy per week over four days (McQuillan et al., 2005; Perroud, Uher, Dieben, Nicastro & Huguelet, 2010).

Within mental health services it is estimated that 30 – 40% of inpatients met criteria for a PD (Casey, 2000). Often those diagnosed with a PD meet criteria for more than one PD diagnosis (Tyrer & Ferguson, 2000) and often present with comorbid axis I disorders based on the DSM-IV classification system (APA, 1994). Zanarini et al. (1998) identified major depressive disorder, anxiety disorders and eating disorders as the most common of these co-morbidities. Service users with a diagnosis of PD are a high-risk population due to the

characteristics of suicidal ideation, suicide attempts, self-harm, substance use, self-neglect and chaotic lifestyles (Feigenbaum et al., 2012). Historically service users with borderline features (BF) have been one of the most difficult populations to engage in treatment and were found to have low treatment completion rates (Gunderson et al., 1989). People with BF experience interpersonal sensitivity, emotional lability, anger and impulsivity and it is these traits which are thought to contribute to premature withdrawal from treatment (Wnuk et al, 2013). For this population not completing treatment can be associated with more persistent and negative outcomes compared with treatment completion or no treatment at all (Dahlsgaard, Beck & Brown, 1998) and this can have a negative impact on therapists, health care agencies and society (Swift & Greenberg, 2012). Therefore, engaging and retaining service users in therapy is important for achieving good clinical outcomes for the service user as well as ensuring the cost-efficiency of clinical services (Webb & McMurran, 2009). A recent meta-analysis of treatment completion in psychotherapy models that have been shown to be effective for people with BF found that 75% of service users complete treatment which Barnicot, Katsakou, Marougka and Priebe (2011) argued should change the perception of people with BF as having poor treatment rates. They highlight that this may be because there are now more specialised treatments available and that stigma associated with exhibiting BF may have reduced as a result of the publication of "Personality Disorder: No longer a diagnosis of exclusion" (NIMH (E), 2003).

One of the aims of DBT is to reduce dropout rates through engaging in strategies that increase commitment to therapy (Linehan, 1993). One such strategy is engaging the service user in a collaborative assessment process through which the formulation is shared with the client from an inquisitive and hypothesis testing perspective. Further DBT strategies to maximise engagement include treatment contracts, using motivational strategies to gain commitment to treatment goals, validation (acceptance), dialectically informed commitment strategies, for example, using metaphors and engaging in the "devil's advocate" technique (Ben-Porath, 2004). Employing this technique, therapists ask clients if they are sure they want to engage in the therapy and highlight how hard it will be, causing the client to argue in

favour of why and how they will complete the therapy and not drop out. The dropout rates for DBT vary across studies, for example, 12% (Bateman & Fonagy, 1999), 39% (McMain et al., 2009) and 67% (Zinkler, Gaglia, Arokiadass & Farhy, 2007). This may be due to a number of factors, such as different healthcare systems and/or because the definition of dropout varies across studies (Swift & Greenberg, 2012; Wierzbicki & Pekarik, 1993)

Several studies have examined factors associated with dropout of people with BF from treatment and have identified a range of factors; however there is an emerging evidence base focused on factors specifically related to non-completion of DBT for features of personality difficulties (FPD). This review aims to answer the question 'What is known about why participants do not complete DBT programmes for FPD and about the characteristics of these participants?' by synthesising and critically appraising the relevant literature exploring the factors related to participant dropout or premature termination from this evidenced based programme. The reasons why participants drop out of DBT will be of particular interest to DBT therapists in relation to suitability for DBT and in finding ways to support those in DBT to complete the programme. It will also be of interest to commissioners of DBT programmes in relation to structuring DBT services and to maximise cost-effectiveness. The author is aware of a systematic review conducted by McMurran, Huband and Overton (2010) in relation to non-completion of PD treatments. While there is some overlap between this study (three papers) and the present one there was enough new literature in the past five years to warrant a review specifically in relation to DBT for FPD.

Methodology

The literature review was conducted using a systematic review process. To capture relevant papers, the electronic databases PsycINFO, PubMed, CINAHL, Web of Science, Medline and Scopus were searched in January 2015 for English-language only papers but with no restrictions in relation to date of publication. The search in Web of Science was refined for psychiatry and psychology references. The Cochrane Library website and the reference lists of all the key articles were also searched. No unpublished papers were

identified on SIGLE. Scoping searches helped to identify the most appropriate search terms which were: "dropout" OR "end*" OR "rupture" OR "finish" OR "terminat*", AND "dialectical behavio#r therapy" OR "DBT".

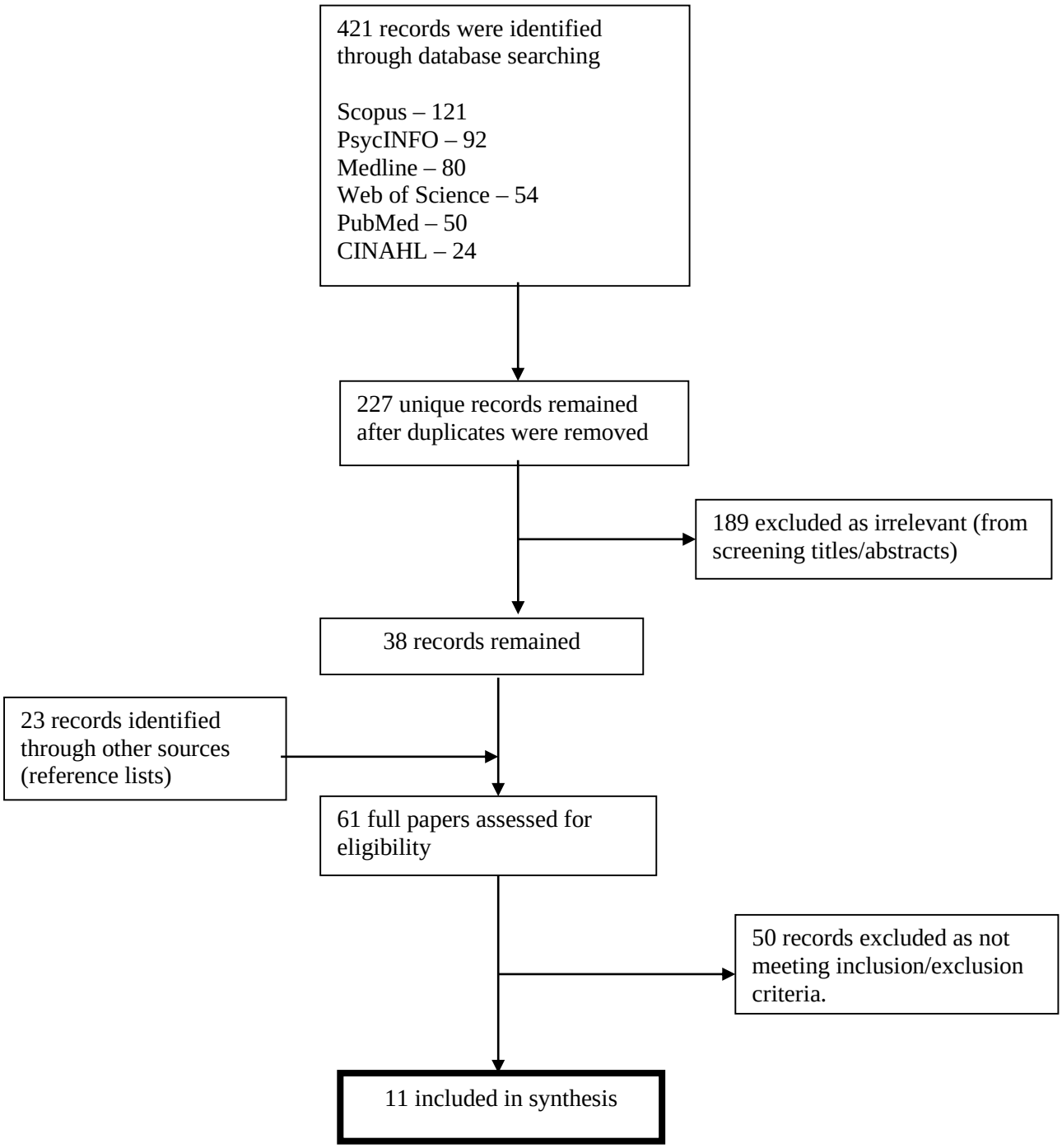
The papers were reviewed and screened in relation to the predetermined inclusion and exclusion criteria firstly at title and abstract level and then, if appropriate, the full paper was reviewed. The inclusion criteria were (a) an empirical study (controlled or uncontrolled) looking at DBT for FPD with data in relation to factors or reasons for dropout from the DBT programme, (b) participants aged at least 18 years (c) participants to have a diagnosis of a PD or features of personality difficulties (assessed by personality assessments and/or screening questionnaires and therefore diagnosis cannot be inferred) and (c) papers written in the English language. Exclusion criteria included (a) studies that adapted DBT for other primary diagnoses, post-traumatic stress disorder (PTSD), substance use and psychological difficulties related to clinical health (b) studies conducted in a forensic setting and (c) studies evaluating the effectiveness of medication as an adjunct to DBT. Studies were not excluded if the participants presented with co-morbidity, only if the DBT programme was amended to target something other than FPD. There were two sets of papers that used the same sample or subsets of the same sample (1) Bohus et al. (2004) and Rusch et al. (2008) and (2) McQuillan et al. (2005) and Perroud et al. (2010). All papers were included because they examined different factors in relation to dropout and contributed unique findings to the review.

After removing duplicates, titles and abstracts of 227 potentially relevant papers were examined and 189 citations were excluded as irrelevant. The full text of the remaining 38 records along with 23 records identified through hand searches were reviewed and 11 studies were retained in the review (see *Figure 1*).

The quality assessment checklist developed for this particular review combined elements of Jackson et al.'s (2006) "Graphical appraisal tool for epidemiological studies (GATE)" and elements of the Critical Appraisal Skills Programme cohort study checklist (CASP, 2010) for the observational studies (Table 1). The other checklist utilised the CONSORT 2010 checklist for controlled trials (Table 2; Schulz, Altman & Moher, 2010).

This enabled an appraisal of each paper's study design and internal and external validity. The papers were assessed against the checklist criteria and two of the papers were also quality assessed by a colleague. The discussion section explores potential biases and limitations of the studies based on this quality assessment.

Figure 1. Flow chart of searches and study selection



Results

The characteristics (*Table 3*) and findings (*Table 4*) of the 11 studies included in this review are synthesised in separate tables. While all of these studies provided data either in relation to why participants do not complete DBT for FPD, or in relation to the characteristics of participants who did not complete DBT, the studies differed in a number of ways. Firstly, the DBT programmes differed in relation to the setting and the length of the programmes. Some of the programmes were delivered for outpatients and included all of the modules as described by Linehan (1993) either over a 12-month period (Feigenbaum et al., 2012; Gaglia, Essletzbichler, Barnicot, Bhatti & Priebe, 2013) or a 6 month period (Stanley et al., 2007). While some were adapted for a three month open door inpatient environment (Bohus et al., 2004; Kroger, Harbeck, Armbrust & Kliem, 2013; Kroger, Röpke & Kliem, 2014; Rusch et al., 2008), another sample was evaluated from an outpatient I-DBT three or four week programme (Perroud et al., 2010; McQuillan et al., 2005). Other programmes did not provide all of the components of DBT, for example, Soler et al. (2008) evaluated a three month DBT-I programme comprised of skills training and phone coaching and Webb and McMurran (2009) compared completers and non-completers of an open-ended community based DBT programme but with no phone coaching. Furthermore, the definitions of non-completion differed between the studies with some studies not defining non-completion (Feigenbaum et al., 2012; Gaglia et al., 2013; Perroud et al., 2010; Stanley et al., 2007) while other papers were unclear in relation to what classified as non-completion (Bohus et al., 2004; Soler et al., 2008). Only one study, Kroger et al. (2014) differentiated between those who were expelled from therapy and those who dropped out.

Of the 11 studies in this review, nine are observational studies and two are controlled trials (Bohus et al., 2004; Feigenbaum et al., 2012). Four studies were carried out in Germany (Bohus et al., 2004; Kroger et al., 2013; Kroger et al., 2014; Rusch et al., 2008), three in the UK (Feigenbaum et al. 2012; Gaglia et al., 2013; Webb & McMurran, 2009), two in Switzerland (McQuillan et al., 2005; Perroud et al., 2010), one each in Spain (Soler et al., 2008) and the United States of America (Stanley et al., 2007) respectively.

Table 1: Quality assessment for observational studies

Study reference	Population & Recruitment						DBT	Screening and data collection			Attrition		Analysis			Checklist items met
	Target population defined	Eligibility criteria	Representative of identified population	Recruitment process described	Nonparticipation among eligible participants	Baseline characteristics	Description	Measures - reliable	Measures - valid	Inter-rater reliability – diagnostic instruments	Non-completion defined	Attrition data	Statistical methods appropriate	Missing data accounted for	Confounding factors considered	
1) Gaglia et al. (2013)	U	P	U	Yes	N/S	Yes	P	N/S	N/S	N/S	No	Y	Yes	N/S	Yes	4
2) Kroger et al. (2013)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	N/S	N/S	Yes	Yes	Yes	Yes	Yes	12
3) Kroger et al. (2014)	Yes	Yes	Yes	Yes	N/S	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	14
4) McQuillan et al. (2005)	Yes	Yes	Yes	Yes	N/S	Yes	Yes	N/S	N/S	N/A	Yes	Yes	Yes	N/S	Yes	10
5) Perroud et al. (2010)	Yes	Yes	Yes	Yes	N/S	Yes	Yes	P	P	N/A	No	Yes	Yes	N/S	Yes	9
6) Rusch et al. (2008)	Yes	EP	Yes	Yes	N/S	EP	EP	N/S	N/S	EP	Yes	Yes	Yes	N/S	Yes	7
7) Soler et al. (2008)	Yes	Yes	Yes	Yes	N/S	Yes	Yes	N/S	N/S	N/S	U	U	Yes	N/S	Yes	8
8) Stanley et al. (2007)	Yes	Yes	Yes	Yes	N/S	N/S	P	N/S	N/S	N/S	No	Yes	N/A	N/A	N/A	5
9) Webb & McMurran (2009)	Yes	P	Yes	Yes	N/S	P	Yes	P	N/S	N/S	Yes	Yes	Yes	N/S	N/S	7

U=unclear, P=partial, EP=outlined in earlier paper, N/S=not stated, N/A=not applicable

Table 2: Quality assessment for controlled trials

Study reference	Population & Recruitment								Blinding		DBT and control		Screening and data collection			Attrition		Analysis				Checklist items met
	Target population defined	Eligibility criteria	Representative of population	Recruitment process described	Control group randomised	Nonparticipation among eligible participants	Baseline characteristics	Groups similar at start?	Outcome assessor blind	Participant aware	Description of DBT	Description of control	Measures - reliable	Measures - valid	Inter-rater reliability – diagnostic instruments	Dropout defined	Number	Statistical methods appropriate	Missing data accounted for	Differences at baseline adjusted for	Confounding factors identified	
10) Bohus et al. (2004)	Yes	Yes	Yes	Yes	No	Yes	Yes	P	N/S	Yes	Yes	U	N/S	N/S	Yes	U	Yes	Yes	N/S	Yes	Yes	13
11) Feigenbaum et al. (2012)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	N/S	N/S	Yes	N/A	N/A	N/A	Yes	16

P=partial, U= unclear, N/S=not stated, N/A=not applicable

Table 3: Study characteristics

Study Reference	**Design**	**N and participant characteristics**	**Assessment tools and findings**	**Definition of non-completion Non-completion rate (%), N**	**DBT programme and duration**
1) Gaglia et al. (2013)	Observational study comparing completers and dropouts	N=102 88.2% female 11.8% male Mean age: 32.4	Structured Clinical Interview for DSM-IV Axis II Disorders (SCID-II; First, Gibbon, Spitzer, Williams & Benjamin, 1997) Avoidant PD 62.8%, Dependent PD 23.5%, Obsessive-compulsive PD (OCPD) 46.1%, Paranoid PD 49%, Schizotypal PD 14.7%, Schizoid PD 6.9%, Histrionic PD 2%, Narcissistic PD 12.8%, Borderline PD 99% and Antisocial PD (ASPD) 19.6%.	- *Non-completion not defined* - 58%, N=59	- Outpatient DBT - 1 Year
2) Kroger et al. (2013)	Observational study comparing pre and post outcomes	N=1423 75.5% female 24.5% male Mean age: 32 (SD=10.27)	SKID-I (Wittchen, Wunderlich, Gruschitz & Zaudig, 1997) SKID-II (Fydrich, Renneberg, Schmitz & Wittchen, 1997) BPD 100% On average each participant had 3.7 (SD=1.59) Axis I disorders and 0.90 (SD=0.6) Axis II disorders, in addition to BPD.	- Discontinuation with or without physician consent or transfer. - 10.4%, N=148 (N=93 missing data, therefore N=55 for complete data in relation to non-completion).	- Open door inpatient DBT: individual therapy (1/week; 50 min), psycho-educative group (1/week; 50 min), skills training (2/week; each 100 min), mindfulness training (1/week; 60 min), participant led practice groups. Further components were movement therapy and art therapy (2/week; 100 min), weekly "Patient Parliament" and a carers/friends meeting once every six weeks. - 3 months
3) Kroger et al. (2014)	Observational study	N=541	Mini-International Neuropsychiatric Interview (MINI; Sheehan et al,	- Non completion of full 84 days of assigned treatment	- Open door inpatient DBT - 3 months

	comparing completers and non completers	90.4% female 9.6% male Mean age: 29 (SD=8.237)	1998) Module for BPD in the SKID-II (Fydrich et al., 1997) BPD 100% <u>Co-morbidity</u> 85.7% mood disorders, 46% anxiety disorders, 31.8% EDs and 46% substance abuse disorders.	- 32.5%, N=176 (100 dropped out and 76 were expelled)	
4) McQuillan et al. (2005)	Observational study of predictors of dropout	N=121 81% female 19% male Mean age: 30.7 (SD=8.1)	International PD Examination Screening Questionnaire for Axis II pathology (IPDE; Loranger et al., 1994) Paranoid PD 53%, Schizoid PD 33%, Schizotypal PD 51%, Histrionic PD 43%, ASPD 36%, Narcissistic PD 32%, Borderline PD 92%, OCPD 57%, Dependent PD 74% and Avoidant PD 82%.	- Those who completed pre and post measures were considered to have completed the programme. - 18%, N=16	- Outpatient I-DBT - 3 weeks
5) Perroud et al. (2010)	Observational study comparing completers and non-completers	N=447 83% female 17% male Mean age: 30.91 (SD 8.5) Second course of treatment N=103	IPDE – Screening Questionnaire (Loranger et al., 1994) Clinical interview BPD (N=418) PD and impulse control disorder (N=29)	- *Non-completion not defined* - First course of treatment: 19.91%, N=89 Second course of treatment: 26%, N=27	- Outpatient I-DBT - 3 weeks (1998 – 2002) 4 weeks (2002 – 2008)
6) Rusch et al.	Observational	N=60	SCID-II (First et al., 1997)	- Leaving therapy before the end of	- Open door inpatient DBT

(2008)	study of predictors of dropout	100% female Mean age: 27.8 (SD=6.9)	MINI (Sheehan et al., 1998) BPD 100% <u>Comorbidity</u> 42% current major depression, 38% PTSD, 42% alcohol or substance abuse and 24% ED.	the 11th week of the 12 week programme. - 32%, N=19	- 12 weeks
7) Soler et al. (2008)	Observational study	N=79 86% Female 14% Male Mean age=27.4 (SD=5.66)	SCID-II (Gomez-Beneyto et al., 1994) Revised Diagnostic Interview for Borderlines Revised (DIB-R; Zanarini, Gunderson, Frankenburg & Chauncey, 1989) Clinical Global Impression of Severity Scale (CHI-S; Guy, 1976) BPD 100% <u>Co-morbidity</u> 73% also met criteria for at least one other PD in the SCID-II.	- *Non-completion is unclearly defined. The following is mentioned in the results section;* "dropped out before completing all DBT group sessions" (p.422) N=9 (not stated in paper)	- Adapted outpatient DBT (skills training and phone coaching) - 3 months
8) Stanley et al. (2007)	Observational study comparing pre and post outcomes	N=20 85% female 15% male Mean age: 32.2 (SD=8.7)	SCID-I (Spitzer, Williams, Gibbon & First, 1990). SCID-II (First, Spitzer, Gibbon & Williams, 1996) BPD 100%	- *Non-completion not defined* - 5%, N=1	- Outpatient DBT-B - 6 months
9) Webb and McMurran (2009)	Observational study comparing DBT	N=14 100% female	IPDE ICD-10 interview (Loranger et al., 1999) BPD 100%	- Missing four consecutive weeks of therapy with no valid reason, or client unilaterally deciding to stop attending.	- Outpatient DBT (no phone coaching). - Open-ended

	completers and non-completers	Mean age: 36.9 (SD=9.15)	Differentiated between "simple PD" (PD from one cluster only) and "complex PD" (PD from more than one cluster).	- 50%, N= 7	
10) Bohus et al. (2004)	Naturalistic waiting list (WL) controlled trial	N=60 (DBT N=40 and WL N=20) 100% female Mean age in DBT group: 29.1 (SD=7.2)	SCID-II (First et al., 1996) DIB-R (Zanarini et al.,1989) BPD 100% <u>Comorbidity in DBT group:</u> 70% anxiety disorders 43% major depression and dysthymia 22.6% ED	- Not completing the full programme; "dropped out of treatment before regular termination" (p.490) - 22%, N=19	- Open door inpatient DBT. DBT as described by Linehan (1993) with the addition of psychoeducation classes, extended mindfulness classes and body oriented therapy. - 3 months
11) Feigenbaum et al. (2012)	Randomised control trial (RCT) comparing DBT to treatment as usual (TAU)	N=41 <u>DBT Group</u> n=25 72%female 28% male Mean age: 35.4 (SD 7.8)	SCID- I (First, Spitzer, Gibbon & Williams, 1998) SCID-II (First et al., 1996) In DBT group: BPD 92%, ASPD 28%, Narcissistic PD 4%, Avoidant PD 36%, Dependent PD 8%, OCPD 4% and Paranoid PD 40%	- *Non-completion not defined* - N=14	- Outpatient DBT - 1 year which was renewable

Table 4: Study findings

Study Reference	Outcome measures and data sources	Outcomes in relation to dropout
1) Gaglia et al. (2013)	- MINI (Sheehan et al., 1998) - Brief Psychiatric Rating scale (BPRS; Ventura, Green, Shaner & Liberman, 1993) - Brief Symptom Inventory (BSI; Derogatis & Melisaratos, 1983) - Zanarini rating scale for BPD (ZAN-BPD; Zanarini, 2003) - Patient records	Multivariate logistical regression analysis: History of care coordination was the only variable significantly correlated with drop-out (B=1.77;P=0.03;odds ration (OR)=5.86)
2) Kroger et al. (2013)	- Borderline Symptom List (BSL-95; Bohus et al., 2007) - BSI (Franke, 2000) - Beck Depression Inventory (BDI; Hautzinger, Bailer, Worral & Keller, 1995) - Global Assessment of Functioning Scale (GAF; APA, 1994)	Dropout: non-parametric conditional inference trees - Participants with co-occurring substance use disorders showed a significantly higher risk of discontinuing treatment. Those who were additionally aged ≤ 20 years were particularly at risk.
3) Kroger et al. (2014)	- BSL-95 (Bohus et al., 2007) - BDI (Hautzinger, et al.,1995) - Dissociative Symptom Questionnaire (Freyberger et al., 1998) - Individual therapists recorded the reason for premature termination in the electronic medical record system – this data was later extracted and coded.	No socio-demographic characteristics were found to be associated with any type of premature termination. Characteristics associated with premature termination: Analysis for expulsion revealed a significant effect for anorexia nervosa ($p<0.001$) and for alcohol abuse ($p=0.066$) Analysis for dropout revealed a significant effect for suicide attempts ($p=0.031$), indicating a higher risk for those participants who reported more than nine suicide attempts. Those who reported less than nine suicide attempts, but met the criteria of ASPD ($p=0.035$) were also at a particularly higher risk for dropout. The risk appeared to be continuous over a period of time for both characteristics. Participants who reported more than 86 weeks in a psychiatric hospital ($p=0.041$) also showed a significantly higher risk for dropout. This risk was higher during the first half of the inpatient stay.

4) McQuillan et al. (2005)	Beck Depression Inventory (BDI; Beck, Ward, Mendelson, Mock & Erbaugh, 1961) Beck Hopelessness Scale (BHS; Beck, Weissman, Lester & Trexler, 1974) Social Adaptation Self-Evaluation Scale (SASS; Bosc, Dubini & Polin, 1997)	Hospitalisation was the only demographic and/or clinical variable that predicted dropout. Those who dropped out had more antisocial traits (X^2=4.59, df=1, p<0.05). Those who completed DBT had more dependent (X^2=3.98, df=1, p<0.05) and avoidant traits (X^2=6.19, df=1, p<0.05).
5) Perroud et al. (2010)	BSI (Derogatis & Spencer, 1982) BDI (Beck et al., 1961) BHS (Beck, Weissman, Lester & Trexler, 1974) Demographic information: Self-report questionnaire Patient records	First course of treatment: <u>Cox Proportional Hazard Regression - univariate analysis.</u> Low education levels (years of education), high number of lifetime hospitalisations, receiving a disability pension and scoring high on antisocial personality traits were significantly associated with dropout In a multivariate model adjusted on age and gender, only low education level remained a significant predictor of dropout with a hazard ration (HR) of 1.45 for 1 SD decrease in education level (95% confidence interval ranged from 1.19 to 1.76;p<0.001). Second course of treatment: Low level of education was the only significant predictor of drop-out with a HR of 1.19 for 1 SD decrease in educational level (95% confidence interval ranged from 1.00 – 1.43)
6) Rusch et al. (2008)	- Link's Perceived Stigma Questionnaire (PSQ; Link, Cullen, Struening, Shrout & Dohrenwend, 1989) - Acceptance and Action Questionnaire (AAQ; Hayes et al., 2004) - State-Trait-Anxiety-Inventory (STAI; Spielberger, Gorsuch & Lushene, 1970) - Symptom Checklist (SCL-90-R;	No significant difference in age, education, rates of psychiatric co-morbidities or number of previous psychiatric hospitalisations between completers and non-completers. At baseline non completers displayed: - Significantly higher trait anxiety on the STAI (p=0.014) - Significantly higher experiential avoidance on the AAQ (p=0.014) - Significantly less life-time suicide attempts (p=0.012) - A trend for more perceived discrimination as mentally ill and more anger-hostility. <u>Stepwise logistic regression:</u> - a lower number of suicide attempts (B= -0.31, SE=0.14, p=0.03) and higher experiential

	Derogatis, 1977)	avoidance (B= 0.11, SE= 0.05, p=0.03) both significantly predicted dropout from inpatient DBT.
7) Soler et al. (2008)	University of Rhode Island Change Assessment (URICA; McConnaughy, DiClemente, Prochaska & Velicer, 1989)	No statistically significant baseline demographic differences between dropouts and completers. The individuals assigned to the precontemplation stage were more likely to drop-out than other participants, X^2 (1, N=60)=7.00, exact p value=0.023
8) Stanley et al. (2007)	Participant reported reason for dropout (Stanley, personal communication, March 13, 2015)	Participant could not tolerate the skills group. Drop-out occurred during the commitment phase within the first month.
9) Webb & McMurran (2009)	- Treatment Motivation Questionnaire (TMQ; Ryan, Plant, & O'Malley, 1995) - Hospital Anxiety and Depression Scale (HADS; Zigmond & Snaith, 1983) - Social Problem Solving Inventory Revised (SPSI-R; D'Zurilla & Nezu, 2002). - Electronic patient record	<u>Age: Mann-Whitney test</u> No significant difference in age between the two groups ($U_{(7,7)}$ = -1.06, p>0.05) <u>PDs: Fisher's exact probability test (p<0.02, two-tailed)</u> - Greater number of PDs: continuers mean 1.57 PDs, SD=1.13; discontinuers mean 4.29, SD =2.43; p<.02. - Greater severity of PDs: 5 continuers had simple PD, two had complex PD; all 7 discontinuers had complex PD. <u>Motivation: Mann Whitney U tests (p<0.01)</u> Those who discontinued therapy had significantly more external reasons (Mean=12.80, SD=3.27) to be in therapy compared with those who continued (Mean=5.40, SD=1.94) while those who continued therapy reported significantly more internal reasons (Mean=70.00, SD=2.64) to be in therapy than those who discontinued (Mean =48.18, SD=8.68). <u>Hospital admissions:</u> Discontinuers cost three times as much in hospital inpatient admissions in the nine month period after acceptance into the therapy service as completers.
10) Bohus et al. (2004)	SCL-90-R (Derogatis, 1977)	Comparison of SCL-90-R of the dropout group and the completers at admission and found no significant difference (t= -1.294; p=0.204)
11) Feigenbaum et al. (2012)	Research interviews with those who dropped out	Gender: of 7 men randomised into DBT, only 1 man completed. Co-morbidity: five clients with paranoid PD and six with ASPD dropped out of therapy (this accounts for eight dropouts, as three clients were co-morbid for paranoid PD and ASPD)

		Departure of a therapist from the team: all clients of the departing therapist dropped out of treatment (n=4) Research interviews with dropouts identified anti-therapeutic aspects that lead to their dropout: - Fear in relation to other clients of the service with ASPD - Non-BPD clients reported frustration and irritation as the could not easily recognise their own symptoms or difficulties in the discussions and hand-outs and reported feeling uncomfortable in the predominantly BPD groups

The results of this systematic review can be separated into four broad categories; personal characteristics, co-morbidity and distress, environmental and relational factors, and motivation.

1. Personal characteristics

There were conflicting findings in terms of the sociodemographic variables found to be associated with noncompletion of DBT programmes. Gaglia et al. (2013) found that men tended to drop out of treatment more often and of the seven men randomised into DBT in Feigenbaum et al.'s (2012) RCT, only one man completed the programme. These results were statistically significant but in other studies gender was not found to have any association with dropout (Kroger et al., 2014; Soler et al., 2008). Four studies showed age had no association with dropout (Gaglia et al., 2013; Kroger et al., 2014; Rusch et al., 2008; Webb & McMurran, 2009), however, Kroger et al., (2013) found that patients who were aged 20 or younger were particularly at risk of dropout. Perroud et al. (2010) found that dropout was associated with fewer years in education but other studies found no link between education and dropout from DBT (Kroger et al., 2014; Rusch et al., 2008; Soler et al., 2008). Perroud et al. (2010) also found that receiving a disability pension and a high number of lifetime hospitalisations were associated with dropout whereas other studies found that history of hospitalisation had no predictive relevance (Gaglia et al., 2013; Rusch et al., 2008). Other sociodemographic characteristics found not to have any association with dropout include employment status (Gaglia et al., 2013; Kroger et al., 2014; Soler et al., 2008) marital status (Kroger et al., 2014; Soler et al., 2008), living situation (Gaglia et al., 2013) or ethnicity (Gaglia et al., 2013).

2. Co-morbidity and distress

In relation to co-morbidity, in Feigenbaum et al.'s (2012) RCT five clients with paranoid features and six with antisocial traits dropped out of therapy (this accounts for eight out of 14 dropouts, as three clients had co-morbid paranoid features and antisocial traits). Webb and McMurran (2009) found that those who did not continue with therapy had more

complex profiles of personality difficulties, for example, they met criteria for personality difficulties from more than one cluster on the IPDE (Loranger, 1999). Perroud et al. (2010) found that scoring high on antisocial personality traits was significantly associated with dropout and Kroger et al. (2014) also found that those who reported less than nine suicide attempts, but also exhibited antisocial traits, were also at a particularly high risk for dropout. Gaglia et al. (2013) found a trend showing that patients with obsessional behaviours were more likely to complete a DBT programme.

In a DBT for inpatient programme, Rusch et al. (2008) found no significant differences in rates of psychiatric comorbidities between completers and non-completers; however, in another inpatient programme, Kroger et al. (2014) found that those with comorbid anorexia nervosa were at higher risk of expulsion especially during the second half of their inpatient stay. Kroger et al. (2013) found that participants with co-occurring substance use at pre-treatment showed a significantly higher risk of discontinuing the inpatient DBT treatment programme. Kroger et al.'s (2014) study found that the reason one third of participants did not complete treatment was due to substance use or possession (15%) according to the therapist's attribution of why participants terminated prematurely and in their analysis of those who were expelled, alcohol abuse showed a higher risk for expulsion.

Bohus et al. (2004) found no differences on the Symptom-Checklist (SCL-90-R; Derogatis, 1977), between completers and non-completers in their trial, indicating higher pre-treatment symptom severity does not predict dropout. The SCL-90-R (Derogatis, 1977) is a 90 item self-report questionnaire yielding nine scores along primary dimensions (somatisation, obsessive-compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, psychoticism, and "additional items") and three scores on global distress indices (global wellness index, hardiness, and symptom free). Webb and McMurran's (2009) research found that the scores on the HADS did not differentiate between completers and non-completers with both groups scoring in the clinical range. However, the outcome for those who did not complete therapy was that they spent, on average, almost three

times longer in hospital than those who continued. Webb and McMurran (2009) suggest that this indicates either increased or more frequent distress in non-completers.

Rusch et al. (2008) found no difference between completers and non-completers in relation to previous psychiatric hospitalisations but they did, however, find that, at baseline, non-completers had significantly higher trait anxiety on the State-Trait-Anxiety-Inventory (STAI; Spielberger et al., 1970). The STAI (Spielberger et al., 1970) is a self-report measure consisting of 40 items used to measure trait anxiety. However, they also found that non-completers had fewer pre-treatment suicide attempts, a trend for more perceived stigma and a trend for more anger-hostility at baseline. As stated earlier, Kroger et al. (2014) also found a significant effect for suicide attempts. Kroger et al. (2014) also found that participants who reported more than 86 weeks of inpatient admissions in psychiatric hospitals over their lifetime showed a significantly higher risk for dropout and this risk increased during the first half of the inpatient stay. Kroger et al. (2014) also found that 10% of participants dropped out due to having no willingness to tolerate emotional distress according to their therapist.

3. Environmental and relational factors

Feigenbaum et al. (2012), Gaglia et al. (2013) and Kroger et al (2014) were the only studies that identified environmental and relational factors as impacting on dropout from DBT. Feigenbaum et al. (2012) found that the departure of a therapist was an identifiable factor in the dropout rate from DBT. Despite significant attempts to retain the therapist's participants, all four dropped out. Feigenbaum et al. (2012) conducted research interviews with participants who dropped out of DBT. The participants cited fear of other group members with antisocial traits as a reason for terminating early. Participants without BF cited frustration and irritation due to not being able to easily recognise their own symptoms or difficulties in the DBT material and they also cited feeling uncomfortable in groups of participants with predominantly borderline features as reasons for dropping out of DBT (Feigenbaum et al., 2012).

Gaglia et al. (2013) found that a history of care co-ordination, which indicated complex needs, was associated with risky behaviour and reduced BF and that it was significantly correlated with dropout. They found that 88% of patients with a history of care coordination dropped out prematurely compared with 52% of patients without such a history. They found that the odds of a patient who receives care coordination dropping out are 5.86 times higher than the odds of a patient who does not receive it (Gaglia et al., 2013).

Kroger et al. (2014) also found that according to therapists, interpersonal factors impacted on dropout with 10.8% of dropouts attributed to repeated arguments with others.

4. Motivation

Webb and McMurran (2009) found that those who discontinued DBT were more externally motivated (demonstrated more external reasons to be in therapy) and were less internally motivated for treatment compared with those who continued. Rusch et al. (2008) found that non-completion was associated with significantly higher experiential avoidance on the Acceptance and Action Questionnaire (AAQ). In Soler et al.'s (2008) research into the stages of change in DBT for BF they found that the pre-contemplation stage in the pre-treatment assessment was directly related to dropout from the DBT programme. Kroger et al. (2014) found that therapists attributed lack of motivation as the reason 13.1% of participants dropped out.

Discussion

The aim of this systematic review was to synthesise and critically appraise relevant research exploring predictive factors and individual characteristics of those who do not complete DBT for FPD.

This review found conflicting results in relation to the sociodemographic factors associated with non-completion which is in contrast to Barnicot et al.'s (2011) systematic review and meta-analysis examining treatment completion in psychotherapy for BF. They found that sociodemographic variables (age, gender, marital status, employment status and

living alone) were not associated with dropout. Barnicot et al (2011) found that symptom severity at baseline, including severity of BF, depression and general psychopathology did not differ between dropouts and completers, however, the findings of this review are conflicted in relation to co-morbidity and distress at baseline. Wnuk et al. (2013) examined factors related to treatment attrition in DBT and General Psychiatric Management, which they described as a psychodynamic approach, however they did not separate out their results by intervention (hence they are not included in this review). They found that a higher number of Axis 1 disorders predicted dropout from DBT and General Psychiatric Management in their combined dataset. In the wider literature in relation to non-completion of PD treatments, McMurran et al. (2010) found that a number of studies found various links between PD diagnoses and completion or non-completion of different therapies; however more data are needed in this area. Wnuk et al. (2013) found that the strongest predictor of dropout was the therapeutic alliance. While none of the studies in this review examined the therapeutic alliance, they did identify environmental and relational factors that impacted on dropout. Therapeutic alliance has been found to be predictive of dropout across populations with BF (Spinhoven, Giesen-Bloo, Van Dyck, Kooiman, & Arntz, 2007; Yeomans et al., 1994) as well with other populations in the wider psychotherapy research (Sharf, Primavera & Diener, 2010). The importance of motivation for engaging with the DBT programme is well recognised in DBT. Linehan et al. (2002) suggested the increased use of validating and motivating strategies before initiating any behavior change could increase retention rates in people with BF with co-morbid substance use. This review identified various factors associated with reduced motivation and non-completion; the link between external motivation (Webb & McMurran, 2009), being in the pre-contemplative stage on the University of Rhode Island Change Assessment (URICA; McConnaughy et al., 1989) and higher experiential avoidance on the AAQ (Rusch et al., 2008). The URICA is a self-report measure used to assess the stages of change consisting of 32 items, 8 for each of the stages of change: precontemplation, comtemplation, action and maintenance. The conflicting results found in

this review and when compared to the wider literature may be explained by the limitations of the review as outlined below.

Limitations of the studies

Generalisability of the findings.

There was considerable heterogeneity across the studies reviewed in this paper which therefore makes it difficult to draw definitive conclusions. The DBT programmes outlined across the 11 studies differed across settings (inpatient/outpatient) and the lengths of the programmes (three weeks to open ended) and the content of the programmes, with some delivering full DBT programmes as described by Linehan (1993) with others omitting elements of it, for example phone coaching (Webb & McMurran, 2009) or individual therapy (Soler et al., 2008) and others adding elements such as: participant led practice, movement therapy, art therapy, carers/friends meetings (Kroger et al., 2013), additional mindfulness training and psychoeducational groups (Bohus et al., 2004; Kroger et al., 2013). While all the studies focused on a population with FPD, they were providing DBT programmes for participants experiencing different levels of distress. For example, Kroger et al.'s (2014) study described an open door inpatient DBT programme for service users who could not be admitted to an outpatient DBT programme due to the severity of their distress while the DBT programmes in other studies were conducted in outpatient settings (Feigenbaum et al., 2012; Gaglia et al., 2013; Perroud et al., 2010; Soler et al., 2008; Stanley et al., 2007; Webb & McMurran, 2009). The content of the programmes tended to be guided by the population, the setting of the programme and service constraints. While the findings may be applicable to their particular setting they are not likely not be generalisable across all DBT programmes.

The sample sizes ranged from 1423 (Kroger et al., 2013) to 14 participants (Webb & McMurran, 2009). Of the 11 studies, five had samples of greater than 80 participants (Gaglia et al., 2013; Kroger et al., 2013; Kroger et al., 2014; McQuillan et al., 2010; Perroud et al., 2010). Research based on very small sample sizes needs to be interpreted with caution because while their findings are valuable they are not generalisable. Furthermore, findings by

Rusch et al. (2008) have to be interpreted with caution since they used a stepwise logistic regression analysis with seven variables for their sample of 60 participants. This is considered a small sample for this statistical analysis and their use of the stepwise method means that they are capitalising on statistical chance. The rates of non-completion ranged from 5% to 58% across the studies, however it seems meaningless to compare these rates due to the varying definitions of non-completion and the wide-ranging sample sizes.

The 11 studies were conducted across five different geographical locations which may also reduce the generalisability of the findings. Gaglia et al. (2013) raised the point that the availability of a free universal healthcare system such as the National Healthcare System (NHS) in the United Kingdom may influence dropout rates where service users may be able to avail of an alternative treatment compared to in United States of America, where that safety net may not be available. In their Canadian study, McMain et al. (2009) also wondered if lower retention rates in their study was due to the availability of publicly funded treatment alternatives.

A confounding variable across all of these studies was pharmacological treatment and its impact on non-completion; for example, the latter could be due to the side effects of medication (Vita, DePeri & Sacchetti, 2011) or undergoing a medication change with their medical team. Three studies, Bohus et al. (2004), Kroger et al. (2013) and Perroud et al. (2010) acknowledged medication as a possible confounding variable but it was not within the scope of their research to investigate this further.

Three of the studies (Bohus et al., 2004; Rusch et al., 2008; Webb & McMurran, 2009) had 100% female participants with the remaining eight studies reporting between 72% (Feigenbaum et al., 2012) and 90.4% (Kroger et al., 2014) female participants. The samples reflect the higher number of females that are referred for DBT programmes for FPD but the results may not be representative for males.

Reliability and validity of the findings.

The studies reviewed in this paper relied heavily on self-report measures and self-disclosures which is common in mental health practice and research but may reduce the reliability of the findings (Gunderson et al., 2011). While the authors did not always specifically outline the reliability and validity of measures, which impacted on their quality assessment rating, often the measures used were commonly known to be reliable and valid. Soler et al. (2008) used the URICA (McConnaughy et al., 1989). This is used to assess motivation for change in relation to a specific behaviour by providing scores on four stages of change: pre-contemplation, contemplation, action and maintenance. However, in their study no specific behavior is the focus of the URICA (McConnaughy et al., 1989). Soler et al. (2008) argued that it is likely that participants answered the URICA (McConnaughy et al., 1989) in terms of their own most severe symptoms however this is a limitation of the study. The data in Kroger et al.'s (2014) study extracted, from the patient record system, the reasons therapists attributed to service users premature termination from DBT. It cannot be ruled out that these reasons were not judgement laden or that there was consideration given to therapeutic factors or the therapeutic alliance (Kroger et al., 2014). Furthermore, therapists and service users frequently differ in the reasons they cite for premature termination of therapy. Hunsley et al. (1999) found that therapists were able to correctly identify positive reasons for termination; however, they were significantly less likely to identify negative reasons for clients' termination.

Nine of the studies in this review were observational studies and did not have a control group which is a methodological limitation. Bohus et al's (2004) control trial was not randomised and therefore selection bias cannot be ruled out and despite being a RCT Feigenbaum et al.'s (2012) data in relation to con-completion was only extracted from the DBT group so the RCT design had no impact on the data. Therefore, the authors across all 11 studies cannot be certain that that the findings in relation to non-completion were unique to non-completion of a DBT programme. Furthermore, Bohus et al. (2004) only compared the

DBT and a wait list control on one measure, SCL-90-R (Derogatis, 1977) which limits their findings.

Regarding the diagnoses of participants, out of eight studies that used the SCID II (First et al, 1997) only two papers reported establishing inter-rater reliability between assessors (Bohus et al., 2004; Kroger et al., 2014). Some studies also used a second instrument which made their findings in relation to diagnosis more robust; Kroger et al. (2014) and Rusch et al., (2008) used the Mini-International Neuropsychiatric Interview (MINI; Sheehan et al., 1998) while Soler et al., (2008) and Bohus et al., (2004) used the Revised Diagnostic Interview for Borderlines Revised (DIB-R; Zanarini et al., 1989). Webb and McMurran (2009) used the IPDE – ICD 10 interview but they did not report on inter-rater reliability in relation to the assessors. McQuillan et al. (2010) and Perroud et al. 2010 administered the IPDE screening questionnaire, a self-report instrument and coupled this with a clinical interview to establish a diagnosis. Regarding diagnosis, there are inconsistencies in Gaglia et al.'s (2013) study in relation to their target population. In the abstract they outline that they want to "investigate the characteristics of patients with BPD dropping out from DBT" (p267) however their inclusion criteria state that participants must have a diagnosis of at least one PD but they have not limited it to BPD.

Strengths of the studies

The quality assessment highlighted methodological limitations of the studies however it also highlighted their many strengths. The main strength of these studies is that they are observational studies that have taken place in DBT programme settings across different cultures. The results, therefore, have high external validity and they are applicable to everyday clinical practice. Furthermore all studies clearly reported the number of participants and the attrition rates and the majority of studies clearly outlined their target population and their eligibility criteria. All studies also described their recruitment process and the DBT programme content and all but one of the studies (Stanley et al., 2007) outlined the baseline

characteristics of the participants. The use of reliable and valid outcome measures and appropriate statistical analysis also gives credibility to the results.

Limitations of this review

While this review does highlight important information in relation to non-completion of DBT programmes, there are also limitations associated with it. The definitions of non-completion differed between the studies (see *Table 3*) with some studies not defining it at all. This point is especially pertinent due to the fact that in some studies, for example, Feigenbaum et al. (2012) and Stanley et al. (2007) participants dropped out during the "pre-commitment" stage of therapy, while in other studies they would not have been classified as part of the DBT programme at this stage. Kroger et al. (2013) classified those who discontinued with or without physician consent as con-completers while Webb and McMurran (2009) only considered those who missed four consecutive weeks with no valid reason or who unilaterally decided to stop attending as non-completers. This implies that if the service user did not complete the programme with the agreement of programme facilitators or for a valid reason that it was not classified as a non-completion. Furthermore, Bohus et al. (2004), Rusch et al. (2008) and Soler et al. (2008) classified anyone who did not complete the full programme as non-completers even if they only missed the last week. Furthermore, Kroger et al. (2014) was the only study to differentiate between service initiated expulsions due to non-adherence to stipulated treatment rules and participant initiated endings. While Webb and McMurran (2009) did not separate out their findings in relation to discharge due to non-attendance and those who dropped out of treatment, they did acknowledge that these subgroups might differ from each other. Webb and McMurran (2009) evaluated noncompletion of an open ended treatment programme which meant that current "completers" could become "noncompleters" even though they may have been on the DBT programme for a considerable length of time.

All of the studies employed different exclusion criteria, for example, some studies did not exclude comorbidity (Feigenbaum et al., 2012; Kroger et al., 2013; Kroger et al., 2014;

Soler et al., 2008; Stanley et al., 2007) while others excluded ED if it was the principal problem (McQuillan et al., 2010) or a comorbidity (Bohus et al., 2004; Perroud et al., 2010; Rusch et al., 2008). This was also the case for substance use, which was not excluded by Kroger et al. (2013), Kroger et al. (2014) or Stanley et al. (2007) but it was by other studies if it was the principal problem (Feigenbaum et al., 2011; McQuillan et al., 2010) or a co-morbidity (Bohus et al. 2004; Perroud et al., 2010; Rusch et al., 2008; Soler et al., 2008). Webb and McMurran's (2009) exclusion criteria in relation to comorbidity were vague; "serious co-occurring problems (e.g. psychosis)" and Gaglia et al. (2013) did not outline their exclusion criteria. Furthermore, some studies did not assess for axis II co-morbidity (Rusch et al., 2008) which might have contributed to dropout. Barnicot et al. (2011) highlighted that more stringent exclusion criteria can sometimes exclude more challenging clients before treatment begins which can then influence the findings. While these are acknowledged limitations, in a review of psychotherapy for people with BF, Barnicot et al. (2011) found no association between "treatment setting, length, intervention, exclusion criteria, attendance rules and other study characteristics" and completion rates in their meta-analysis. However, they did question if the meta-analysis had sufficient power to detect this.

The studies included in this review used different outcome measures which makes it difficult to establish a consistent pattern in relation to predictive factors and individual characteristics associated with dropout of DBT for FPD. The variety in outcome measures used reflects the different hypotheses being tested and the disparity between what clinicians and researchers view as potential factors contributing to dropout. Thus overall, the extent of variability precludes the drawing of clear conclusions on the factors that influence non-completion.

Implications for future research

While these 11 studies represent a good start in relation to gathering quantitative data around reasons for non-completion of DBT programmes, the research in this area has so far focussed on inherent deficits in the client as an explanation for treatment non-completion

rather than investigating factors to do with the service delivery or process, for example service related barriers to completing DBT programmes, and the service users' opinions of the service (McMurran et al., 2010). Feigenbaum et al. (2012) and Stanley et al. (2008) did ask participants why they discontinued but this was not the focus of their research. It would be valuable for therapists and services to have qualitative data in relation to reasons for non-completion gathered by an independent research team. Another area of interest is therapist adherence to the DBT model. It would be important for services to know if therapist competence and adherence to the model impacts rates or reasons for non-completion. Both qualitative research with participants around non-completion and research in relation to therapist adherence to the DBT model would add to the existing literature in this area.

Another area that none of these papers have addressed is the timing and appropriateness of referrals of service users to DBT programmes. Research into this would highlight whether or not psychological services are being utilised appropriately within the wider healthcare system if earlier identification of difficulties impacts on retention in treatment.

Conclusion

The results from this review highlight the complexity of factors involved in non-completion of DBT for FPD. It is important to note that not all premature endings represent a failure and that participants who ended prematurely may have either already experienced clinically meaningful change or life circumstances prevent them from continuing the programme (McMurran et al., 2010). While researchers can look for common characteristics across those who do not complete therapy, unless service users are interviewed we can only speculate as to their reasons for terminating prematurely. That said, when clients have negative reasons for ending treatment, they often report satisfaction with the services in general (Hunsley et al., 1999) making it difficult to establish genuine reasons for non-completion. It is likely that a multiplicity of factors are involved in service users' decisions to end prematurely. However, any information that can decrease attrition to therapy is not only

beneficial for individual service users to maximise the potential for therapeutic gains but also for therapist morale, reduced disruption to therapeutic groups and cost effectiveness of services (McMurran et al., 2010).

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University of Liverpool

An exploration of service users' experiences of ending Dialectical Behavioural Therapy (DBT).

Chapter 2: Empirical Paper

Moninne McCormack

Abstract

Little is known about termination experiences of dialectical therapy for individuals with borderline features from their own perspectives. This study aimed to explore participants' experiences of ending a DBT programme and how this experience has influenced their perception of previous endings and management of future endings. Six women were interviewed and their transcripts analysed using Interpretative Phenomenological Analysis. Four key themes were found: (1) fear arising from the powerful influence of previous experiences of ending, (2) engagement with the therapeutic structure of DBT to manage the ending, (3) experiencing the ending of DBT as a reparative process and (4) personal growth during the DBT programme resulting in an awareness of enhanced resilience for the future. Clinical implications highlight the importance of services and therapists to provide an experiential reparative process of therapy termination for service users.

Keywords: Borderline Personality Disorder; dialectical behaviour therapy; ending; therapy termination; individuals' experiences; interpretative phenomenological analysis; qualitative research.

Introduction

Approaches to therapy termination vary across therapeutic models and can depend on whether they are long term, short therm, open ended or time limited. Therefore the beginning of therapy also determines the end in how the termination will be planned for and experienced (Mander, 2000). In psychoanalytic literature, Ticho (1971) described stages of termination; focusing on the patient, beginning with the pre-therapy period, the beginning of therapy, the middle phase, the termination phase and the post-therapy phase. However, while many practitioners believe that termination is an important process of therapy (Gelso & Woodhouse, 2002; Quintana, 1993; Roe et al., 2006b; Yolom, 2005) minimal empirical research has focused on clients' experiences of termination (Knox et al., 2011).

Research in relation to therapy terminations has focussed on therapists' perspectives (Baum, 2005; Fortune et al, 1992; Fragkiadaki & Strauss, 2012; Renk & Dinger, 2002; Quintana & Holahan, 1992) and more recently from the clients' own perspective (Hudgins, 2013; Knox et al., 2011; Roe et al, 2006a; Roe et al., 2006b). Qualitative research conducted by Fragkiadaki and Strauss (2012) on psychoanalytic and psychodynamic therapists' experiences of termination found that their grounded theory model reflected Ticho's (1971) stages of termination. They propose that the therapeutic process and the termination stage are not mutually exclusive. Quantitative and qualitative research focussing on clients' experiences of therapy termination has focussed on the reasons for therapy termination, for example, achievement of treatment goals, dissatisfaction, financial constraints, need for independence and involvement in new meaningful relationships (Roe et al., 2006a) and their feelings during termination of psychodynamically oriented psychotherapy (Roe et al., 2006b). Knox et al. (2011) conducted qualitative research on service users' experience of termination from individual psychotherapy. They found that those who had positive termination experiences reported discussing termination in advance with their therapist, a strong therapeutic alliance and positive therapeutic outcomes. In contrast, those who had problematic terminations usually terminated abruptly because of a rupture and they reported a weak therapeutic alliance and variable therapeutic outcomes (Knox et al., 2011). Hudgins

(2013) identified four overarching themes in relation to the experiences of the termination process of a time limited music therapy group in an adult community mental health setting; (a) recognition of achievements, (b) recognition of challenges, (c) negative feelings experienced in response to termination, and (d) ways of coping with termination.

According to Fragkiadaki and Strauss (2012) a therapeutic relationship differs from other relationships in that there is an expectation of it being time limited. However, studies have shown that the termination process can evoke both positive and negative emotions. Negative emotions associated with termination are grief, loss, sadness and anxiety (Gelso & Woodhouse, 2002; Kramer, 1986; Roe et al., 2006b). However a review of the research on psychotherapy termination found that positive feelings outweighed negative ones (Gelso & Woodhouse, 2002; Roe et al., 2006b). Positive reactions include a sense of accomplishment, self-respect, pride, maturity and independence (Baum, 2005; Fortune, 1987; Knox et al., 2011; Marx & Gelso, 1987; Roe et al., 2006b; Zilberstein, 2008). However, the emotional experience of termination does not end at the last session (Greenberg, 2002) and it is experienced as an on-going process through the post-termination stage. Crawford et al. (2007) evaluated community-based programmes for service users with features of personality difficulties (FPD) and found that, in relation to endings, service users wanted "clear information about, and careful preparation for, endings" (p137). Service users were also concerned that on completion of therapy all access to mental health services would be denied. This appeared to result in the development of 'step-down' programmes through which people could continue to access a less intensive component of the service, for example, peer support groups. Crawford et al. (2007) described termination of therapy as a positive step but that this transition was also experienced as challenging for service users with FPD and highlighted the need for encouragement and planning in relation to endings. Seager (2013) argued that abrupt terminations of therapy could be prevented by graded discharge but while some practitioners caution against tapering off of therapy sessions (Yalom, 2005), others, for example, Goldfried (2002), from a cognitive–behavioural perspective and Greenberg (2002), from an experiential perspective, see it as an important part of the process of termination.

Therapy terminations have also been conceptualised as an opportunity for development through supporting service users to experience a corrective emotional experience and/or a constructive experience of an ending (Mander, 2000; Marx & Gelso, 1987) providing an opportunity to consolidate and preserve therapeutic gains (Roe et al., 2006b). This represents a move away from therapy termination being conceptualised as a crisis point and, instead, a move towards termination as an opportunity for transformation which occurs by highlighting service user progress and the internalisation of the therapeutic processes (Quintana, 1993). While therapeutic endings represent the end of therapy, they are also viewed as new beginnings (Fortune, 1897).

The existing therapy termination research is focussed mainly on psychodynamic therapy or other individual therapies rather than on longer-term time-limited treatment programmes such as dialectical behavioural therapy (DBT). DBT is a skill-based cognitive behavioural programme (Linehan, 1993) and is the treatment of choice for borderline personality disorder (BPD) as recommended by the American Psychiatric Association (APA, 2001), the National Institute for Mental Health in England (NIMH(E), 2003) and the National Institute of Clinical Excellence (NICE, 2009). BPD is characterised by severe cognitive, behavioural and emotional dysregulation as well as dysregulation across interpersonal relationships and sense of self (Kuo et al., 2006). According to DSM-V, individuals who meet criteria for BPD often have a pervasive pattern of instability in interpersonal relationships, self-image and affect as well as markedly impulsive behaviour (APA, 2013). Furthermore, those with a diagnosis of BPD have a lifetime prevalence of self-injurious acts in 75% of cases (Clarkin et al, 1983), with nearly 10% of those diagnosed with BPD taking their own life (Paris, 1993).

Zanarini et al. (1997) found that 91% of those diagnosed with BPD reported some type of childhood abuse (emotional, verbal, physical or sexual) and 92% reported some type of childhood neglect (physical or emotional). As a result disturbed interpersonal relationships and insecure attachment play a central role in people with BF (Agrawal et al., 2004). In their review of attachment studies, Agrawal et al. (2004) found that unresolved, preoccupied and

fearful were the types of attachment most characteristic of people with BF. A longing for intimacy alongside concern about dependency and rejection is characteristic of these attachment types (Agrawal et al., 2004) and as a result individuals with BF struggle to form and to end relationships as a result of their disordered attachment (Feigenbaum, 2007).

One of the aims of DBT is to reduce dropout rates through engaging in strategies that increase commitment to therapy (Linehan, 1993). A systematic review exploring predictive factors and individual characteristics of those who do not complete DBT for FPD found conflicting results (McCormack, 2015). NICE guidelines for the treatment and management of BPD (NICE, 2009) have highlighted the importance of managing endings and supporting transitions in service users with BF. This recommendation is based on service users' personal accounts and on a review of the qualitative literature focusing on their experience of care (NICE, 2009).

Symptom reduction is typically the treatment outcome that is evaluated in empirical research rather than personality change which is the focus of longer term therapies (Holmes, 1997). For many, their experience of ending therapy will be determined by their previous experiences of loss (Holmes, 1997; Pistole, 1999). From an attachment perspective the aim or 'end' of psychotherapy is to help create a secure base, both in reality and as an internal representation within the service user. The establishment of a secure base can take time, especially in those with BF where there may never have been the experience of security (Holmes, 1997).

There are high levels of insecure attachment in people with mental health difficulties and especially in people with BF. Based on an attachment model the role of services is to provide corrective emotional experiences that challenge and modify people's insecure internal working models which can be achieved by providing new opportunities for success and self-efficacy (Bucci et al., 2015).

DBT proposes that BPD is primarily a dysfunction of the emotional regulation system and that individuals lack key interpersonal skills (Feigenbaum, 2007). The programme targets suicidal life threatening behaviours and other destabilising behaviours. It is a manualised

treatment that is typically delivered over 12 months, consisting of weekly skills group, individual psychotherapy, telephone coaching and a weekly consultation meeting for the therapists (Linehan, 1993). Participants in the DBT programme are aware that it is time limited. As part of both the individual therapy and the skills group the ending is planned and discussed with participants from the beginning of the programme and especially as the end approaches and the individual sessions become less frequent.

While there are some qualitative studies exploring service users' experience of DBT (Cunningham et al., 2004; Hodgetts et al., 2007; McSherry et al., 2012; Perseius et al., 2003), to the researcher's knowledge, there are no studies that explore service users' experiences of ending DBT. This is especially important in light of the high incidence of insecure attachment style, interpersonal difficulties and difficulty ending relationships in people with BF (Feigenbaum, 2007). Considering these points, the aim of the present study is to explore participants' experiences of ending a DBT programme and how this experience has influenced their perception of previous endings and management of future endings. The specific objectives set to meet this aim were (1) to explore participants' experiences of ending a DBT Programme, (2) to explore how their previous experiences of endings in either a professional or personal context related to their experience of ending the DBT programme and (3) to explore how people experienced ending DBT reflecting on previous endings in their life and how they will manage future endings.

Methodology

Design

This study employs a qualitative research design using Interpretative Phenomenological Analysis (IPA; Smith et al, 2009) to analyse the data. IPA is concerned with the examination of human lived experience and central to this is the 'double hermeneutic' which is based on the idea that the researcher is attempting to make sense of

participants attempting to make sense of their world (Smith, 2004). They are doing this while also recognising their own contribution in the interpretive process (Smith & Osborn, 2008). See Appendix A for further details. Research into participants' experience of terminating therapy, particularly the experience of people with BF terminating a long-term time-limited programme is in its infancy, hence the importance of collecting rich data and the applicability of IPA (Smith, 2004). Consideration was given to other qualitative methodologies (Appendix B) however IPA was deemed the most suitable since it is concerned with how people make sense of major life experiences (Smith et al., 2009).

Participants

The aim of IPA is to attempt to understand participants' lived experience and how the participants themselves make sense of their experiences. The emphasis in IPA is on the detailed analysis of each case and not on the generalisability of the findings (Smith & Osborn, 2007). As a result most IPA studies recruit a small homogeneous sample of participants (Smith et al., 2009) who share similar characteristics and who all have expertise with the phenomenon being explored (Cohen et al., 2007). For this study, six participants were interviewed which is in line with the Smith et al., (2009) recommendation of recruiting between four and ten participants for a professional doctorate.

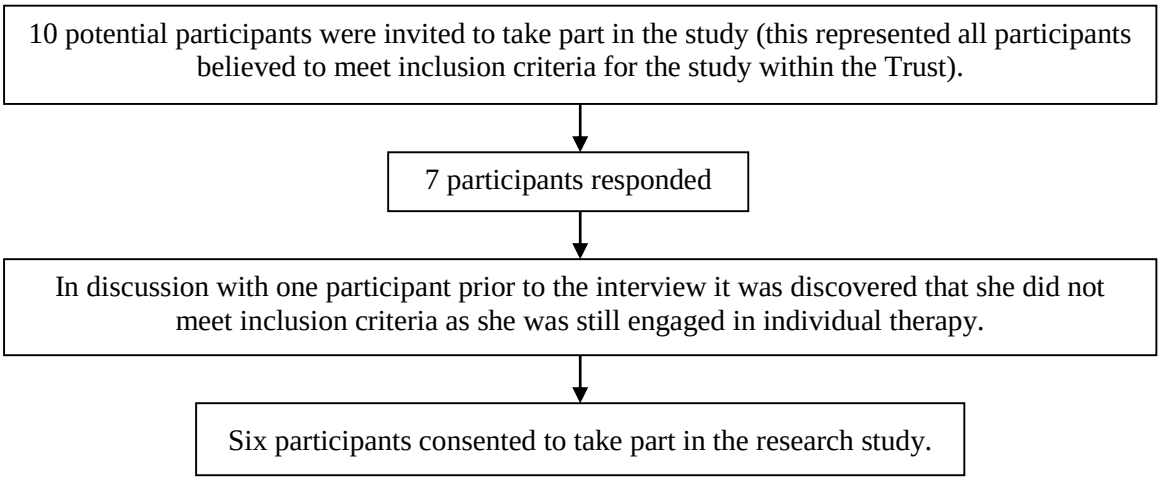
The sample was homogenous; all participants were female, met inclusion criteria for participating in an NHS based DBT programme and had completed the DBT programme within the previous 12 months. The all female sample was dictated by the inclusion criteria of the DBT programmes that the study recruited from.

All participants defined themselves as British, ranged in age between 23 and 47 and were eligible for the study if they met the following inclusion criteria:

- Female
- Presented with BF to meet inclusion criteria for the DBT programme
- Completed an NHS based DBT programme within the previous 12 months. Completion of the DBT programme was defined by completing each module twice,

however, occasionally service users finish after completing each module once; these service users met inclusion criteria if they followed the planned ending and did not drop-out of the programme.

Figure 1: Recruitment of participants flow chart



The study excluded males and service users who dropped out of the programme. The length of stay in the DBT programme ranged between the participants. Two participants completed a six month programme with one participant unsure of the length, stating that her programme lasted between 18 – 24 months. The remaining three participants completed programmes of 12, 15 and 18 months. The time between completion and participating in the research interview also ranged between participants. One participant finished DBT one week prior to the interview while another participant finished 11 months prior. The remaining participants were interviewed one month, five months, six months and nine months post completion. Prior to engaging with DBT the participants had varying experiences of other therapeutic interventions. One participant had never engaged in any other therapeutic interventions while others had engaged in either one or a combination of the following; person centred counselling, cognitive behavioural therapy, a therapeutic community, brief therapy, hypnotherapy, counselling, crystal light therapy, drama therapy, therapy for an eating disorder and psychotherapy. All participants reported that they were not currently engaged in any therapy or support group.

Recruitment

Participants were recruited through the DBT programmes attached to adult mental health (AMH) services in the North West of England. Recruitment took place via DBT therapists who sent a letter and the participant information sheet to service users who met inclusion criteria for the study. Those who consented to being contacted received a phone call from the researcher to discuss the research and to arrange an interview.

Interview design and conduction

IPA requires data derived from participants who had an opportunity to communicate their stories in such a way that they have been able to develop their thoughts, concerns and to speak freely and reflectively (Smith et al., 2009). A conversation with a purpose, such as a semi-structured interview, is an appropriate method to collect such data (Reid et al., 2005) since it is not intended to be prescriptive and it allows the participant to take the lead and the interviewer to encourage and guide the participant through prompts (Biggerstaff & Thompson, 2008).

The interview schedule was developed in line with the study's aims and objectives. The questions explored the individual's experience of ending the DBT programme; their expectations and how their expectations compared to their actual experience; the role DBT had in preparing them for the end of the programme and for endings or transitions in their life in general; other factors that may have impacted on their experience of ending the DBT programme, including the impact of previous endings or transitions in their lives; how they envisage experiencing future endings and whether their understanding of endings has changed since participating in the DBT programme. The researcher used prompts to encourage participants to talk in detail about their experiences. A pilot interview was conducted to assess the interview schedule following which, after consultation with supervisors, no changes were made. The pilot interview was therefore included in the final analysis.

Interviews were arranged at NHS premises convenient for the participants. At the start of each interview the researcher discussed the research with the participants through

revisiting the information sheet and answering any questions before obtaining informed consent. All participants agreed to answer the brief demographic questionnaire and interviews lasted between 25 – 90 minutes and were audio-recorded using a Dictaphone. The researcher transcribed two interviews and a transcriber approved by the University transcribed the remainder.

Ethical considerations

This research was approved by the University of Liverpool Doctorate of Clinical Psychology Research Committee and sponsorship was granted by the Liverpool Health Partnership Joint Research Office. Ethical approval was granted by the NHS Research Ethics Committee (Reference: 14/NW/0286). Ethical considerations were addressed in the information sheet provided in advance of the research interview to all participants. All interviews were anonymised and participants were given pseudonyms to preserve anonymity. In the event that participants became distressed during the interview a protocol was developed which included checking in with participants and providing them with an information sheet at the end of the interview that outlined further support available to them.

Reflexivity

Finlay (2008) describes how IPA researchers are caught up in a "dialectical dance" where they constantly are moving between positions, for example, "between striving for reductive focus and reflexive self-awareness" or "between bracketing pre-understandings and exploiting them as a source of insight" (p.1). The researcher is trying to focus on the lived experience being studied while both controlling and questioning her own understandings. A process of active self-reflection needs to be undertaken at the beginning of the research, during data collection and analysis (Finlay, 2008) which is why the researcher kept a reflective diary to record details and thoughts in an attempt to acknowledge any evolving interpretations (Biggerstaff & Thompson, 2008).

To enhance reflexivity, quality and validity, two different interviews were read by

each research supervisor to validate the emerging and superordinate themes. Discrepancies and queries were discussed and particular attention was paid to ensure that the themes were grounded in the research data.

Position of the researcher

The researcher is a 33 year old white Irish female who is currently in her final year of a clinical psychology training course. Prior to clinical psychology training she worked as an assistant psychologist and a research assistant, which has resulted in many years of working within the field of AMH.

During her six-month AMH placement on the clinical training course, the researcher was a member of a DBT team and co-facilitated the weekly skills group. This first-hand experience of working as part of a DBT team allowed the researcher to bear witness to and be involved in many conversations in relation to service users ending the DBT programme. These conversations often highlighted the dialectics involved in this decision making process primarily from staff members' points of view with the individual therapist representing the views of the service user. This process highlighted the importance of the consultation team as a safe and supportive environment for these issues to be discussed while allowing other staff members to raise the opposing dialectic. While the researcher felt that she had good insights into the thought processes of the staff members in relation to managing endings with service users she was aware that the service users may have had a different experience which led to her interest in this particular area. It has been two years since the researcher was involved in DBT which has allowed distance to reflect on the impact of this experience on her beliefs, assumptions and biases in relation to this topic. The decision was also made not to interview participants from the DBT programme where the researcher had had a professional relationship with potential participants. This limited the recruitment pool but the decision was made to maintain homogeneity of the sample.

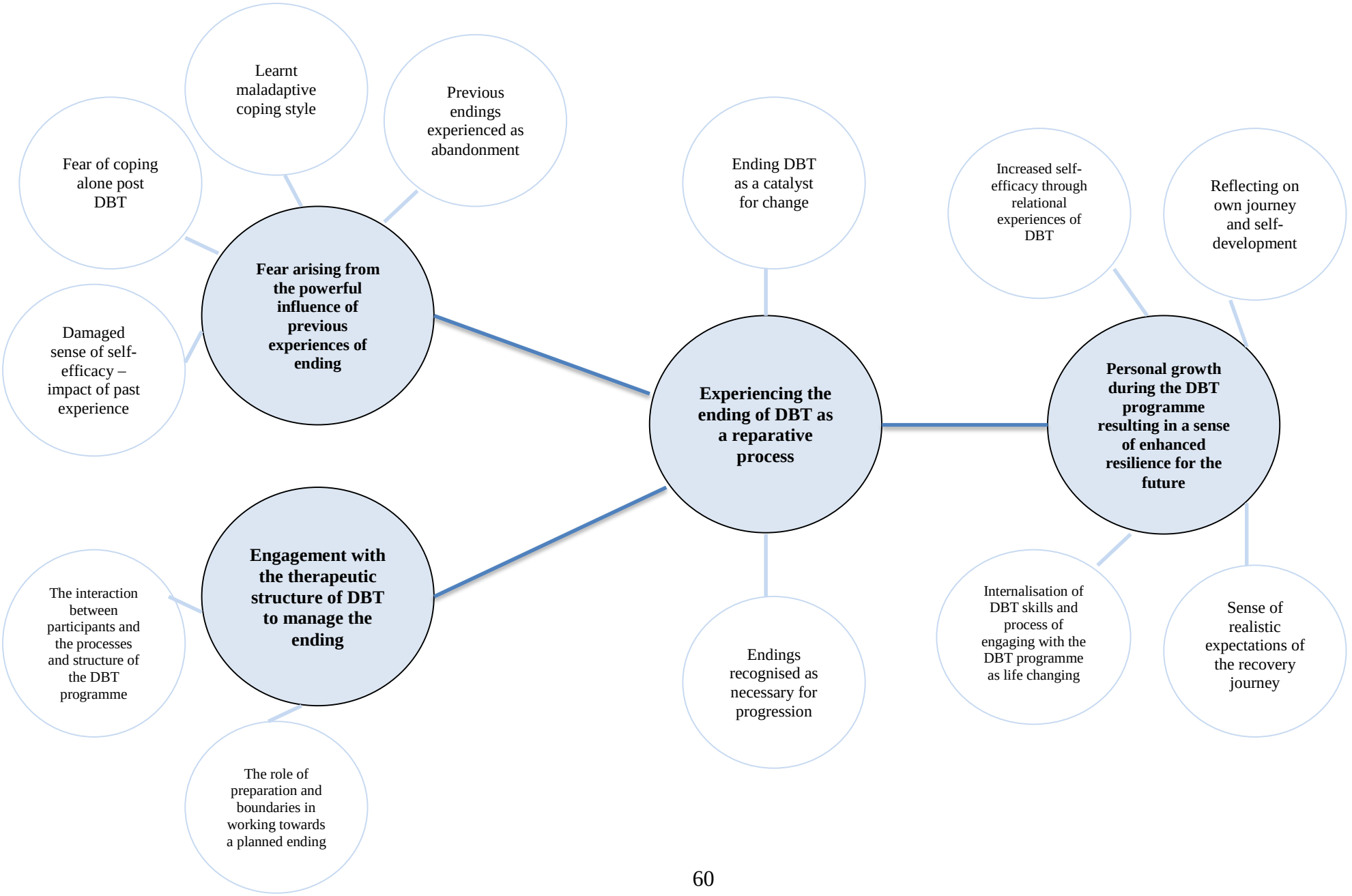
Analytic Procedure

The raw data for this study comprised the six verbatim transcripts of the semi-structured interviews with participants. Analysis followed an integrative and inductive cycle (Smith, 2007) following the six-step process as set out by Smith et al. (2009). The first step involved immersion in the data through listening to the recording and reading and re-reading the transcript. The second step involved initial noting, keeping in mind descriptive, linguistic and conceptual processes and engaging in "analytic dialogue" (Smith et al., 2009, p.84) with the text. The researcher must also engage in "bracketing". This requires an attempt to suspend one's own judgments and assumptions and to explore the meaning for the participant (Husserl, 1999; Spinelli, 2005). In step three, this exploratory coding was used to develop emerging themes. These should feel like they have captured and reflect an understanding of the participant's experience. This was followed by establishing connections and patterns between the emerging themes to develop within-participant superordinate themes. Step five consists of steps one to four being repeated across all of the transcripts while, as far as possible, bracketing the ideas that emerged from the analysis of the previous transcripts. The sixth and final step involves looking for patterns and divergences in the superordinate themes across the transcripts which resulted in two levels of across-participant superordinate themes. Superordinate themes were discarded at this stage if they were not shared by many of the participants or if they did not contribute to the aims and objectives of this study.

Results

Four clear themes emerged from the analysis; (1) fear arising from the powerful influence of previous experiences of ending, (2) engagement with the therapeutic structure of DBT to manage the ending, (3) experiencing the ending of DBT as a reparative process and (4) personal growth during the DBT programme resulting in a awareness of enhanced resilience for the future. These themes along with the 'across participant superordinate themes' are represented in Figure 1.

Figure 2: Relationship between superordinate themes



1. Fear arising from the powerful influence of previous experiences of ending.

The first theme relates to the fear of coping alone that participants felt in anticipation of the end and in the aftermath. The participants made sense of this through their previous experiences of endings or transitions, learnt maladaptive coping mechanisms and the lack of self-efficacy they experienced in the past.

All of the participants made reference to being wary of the lack of support that would be available to them after DBT. DBT was experienced as a *safety net* (Maria, 1,5) and the lack of support that would arise with its end triggered feelings of uncertainty, fear and anxiety based on previous experiences of endings. Frances described how *"you've had like massive support an' then all of a sudden it is taken away from you…an' it's scary"* (1,10-11) and how the therapists *"were my anchor, when you lose that you just float"* (15,409-410). Frances' sense that the ending was *sudden* is in contrast to her later description of knowing that it was a time-limited therapy but her use of *sudden* illustrates feeling out of her control. Her use of *anchor* and *floating* metaphors emphasises the stabilising effect she experienced through her therapeutic relationships and how she anticipated an inability to stabilise herself.

Maria discussed a lack of confidence in her own decision making and invalidation of her own emotions; *"difficult to trust that final judgement and you look to for other people to make you feel that it is the right decision or just for some back up so not to have that support, I think, made me feel nervous"* (2,40-41). This sentiment of being isolated post DBT was echoed by Catherine and Lisa. Lisa was also anxious about maintaining her recovery; *"nobody was ever gonna be there professionally again so if something did happen then it was all down to me"* (3,72-73). In Maria, Catherine and Lisa's descriptions there is evidence of "black and white" thinking and an externalised locus of control in relation to coping in general.

In Hannah's case; *"because I went back to my care co-ordinator there was no kinda fears about endin' DBT but if I did, hadn't gone back my care co-ordinator an' that was sorta it at the end of DBT I think I'd have, well I don't think I'd have ended it after six months" (*2,50-53). Hannah's description was conflicting because she described *no fears* but she also questioned her ability to cope;

"I realised how much it was helpin' me erm it did then cross my mind how was I gonna cope when this came to an end" (10,265-266). Hannah may have been minimising her emotional response to ending, possibility during her ending and during the interview. Throughout her account, Hannah was focused on identifying positives in situations which might have influenced why she emphasised that the relationship *"ended on a high"* (7,169) despite trepidation on her behalf.

Many of the participants described previous endings as triggers for engaging in maladaptive coping strategies; *"I didn't deal with it, I was cuttin' big style, drinkin', blamin' myself (pause) (sigh) but yeah that was hard"* (Frances; 13,399-340). The descriptions of using self-harm, alcohol or prescription drugs to numb or cope with overwhelming emotions were common throughout the interviews in relation to previous maladaptive coping methods in response to endings. As a result, participants were afraid that the termination of DBT would trigger a relapse. Catherine thought; *"my last appointments gonna be awful an' I'm gonna walk out in tears an' I'm gonna end up self-harmin' an' bein' in hospital that night an' I wasn't, I walked out quite happy an' I had a good day an' (pause) (sigh) I'd love to know how they did it (laugh), it was like magic"* (3,75-78). Catherine catastrophised about the ending and demonstrated low self-belief in her ability to cope. Her use of the simile describing her positive experience of the ending being *like magic* emphasises her external locus of control and her inability to take ownership in relation to how she coped at that time.

Participants made sense of their struggle with ending DBT in relation to their past experiences of endings. Maria described how *"...endings are not always a good thing. You know, they are not me driving off into the sunset to a lovely life, they are usually something that is forced upon me and I don't want them to happen…and they create anxiety"* (8,208-208). Previous endings have been experienced by participants as rejecting and abandoning, which has influenced their responses and expectations to endings in general. Maria's use of a happy ever after description highlights how endings in the past have made her feel left behind. Her metaphorical description of *not me driving*, emphasises her sense of feeling out of control. Some of the participants also discussed their past experiences of coping in relation to endings. This illustrated how their internal working models and their learnt maladaptive coping styles were developed. Frances described how *"I've learnt my parents have been wrong, you don't block everythin' in and keep it inside 'cos it's gonna explode out"*

(14,363-364). Frances's description illustrates a sense of growth in relation to understanding that learnt coping strategies, modelled on her parents, were not helpful. Her use of the word *explode* conveys a lack of control and destruction in response to not being able to manage her emotions. Avoidance was also another maladaptive coping strategy in relation to previous endings. Lorraine described how she used to *"literally bundle my whole life up…. resign from my job, sell my house and go away"* (3,83-85). Lorraine described avoiding both the ending and the emotions as a maladaptive coping strategy.

Some participants also tried to avoid the end or prolong the DBT programme in response to their fear. Maria described how she told the facilitators; *"'I still feel mad'… because I was nervous about it finishing"* (2,32-34) and Lisa described how *"… I knew it was coming I was just chose to push it away…. think I didn't wanna feel the emotions that I think and what is associated with it"* (8,207-208). Both Lisa and Maria were able to recognise their reliance on avoidance to cope with the end.

2. Engagement with the therapeutic structure of DBT to manage the ending.

The second theme is in relation to how participants experienced and engaged with DBT. This theme highlights the role that preparation and boundaries played in supporting participants to work towards a planned ending and how participants' interaction with the DBT processes and structures impacted on their experience of the ending.

Many participants spoke about how the programme was described as a time limited therapy and how they began the programme with the end in mind. Maria described how *"they go on about that [ending] from the minute that you start"* (3,73). The therapists managed the participants' expectations of the ending from the outset and this was experienced as containing for the participants. Catherine discussed knowing the end date *"made it easier to (pause) to like detach myself from my therapist an' know that like this is when it's gonna end an' if I knew a definite date that it was gonna end then it was easier to prepare myself (okay) whereas endin' before it's like it's just, it's a sudden unexpected end or (pause) an' an' I haven't been able to prepare for it"* (4,106-109). Catherine compares past endings that were out of her control to the experience of ending DBT in a planned and containing way. Her use of the *definite* also indicates consistency and boundaries in relation to the

structure of the DBT. The participants also discussed how the structure of DBT, for example, tapering of individual therapy sessions prepared them for the end. Catherine described how *"when we were half way through and we had a review erm we knew that, that we were half through an' another so many months it was gonna end but the the taperin' helped"* (4,82-84). While the other participants experienced knowing the end date and working towards it as a collaborative process, Frances was at the other end of the dialectic and experienced it as punitive; *"you were kinda told the date it'd end and that was it, there was no input by us… weren't prepared for it really, except given the date, so yeah it was hard"* (5,131-135).

Regarding interpersonal relationships participants described maintaining boundaries with others in the skills group on the guidance of the facilitators. Lorraine described how; *"you are not encouraged to do that in DBT, to make that emotional connection with other group members but when people break the runes, in a sense then they are storing up trouble for their endings"* (16,437-439). Hannah also described how the DBT model actively tries to support them to make healthy decisions throughout the programme in relation to supporting them to cope with the ending and to focus on themselves as individuals.

Frances described struggling with the generalisation of DBT skills across situations in relation to feeling unprepared for the ending however Lorraine emphasised that the whole DBT programme was preparing them for the end through the different modules; *"Well, I mean all of it is preparing you for the end, because, if your end point is a life worth living then from day one, they are teaching you"* (8,210-211).

DBT was also described as being an active therapy, requiring work and commitment. Maria described making a decision during DBT to be an active participant and Frances described how she had to change her expectations of DBT as the ending approached; *"…'cos it is a personality disorder, it's not gonna go away (sigh) erm so my expectations at first were 'yeah this is gonna take everythin' away, this is gonna be a miracle cure' an' then as I got nearer the end it was like 'it's still helping me but it's me that gotta do the work'…and that's scary, really scary"* (2,51-55). Frances' use of *miracle* implies that during the course she was a passive recipient of care rather than taking an active role as

she describes later. Through both her verbal and non-verbal language (sigh) there is a sense of her feeling exasperated by the experience of DBT, living with FPD and the on-going commitment that DBT skills require.

Some participants, namely Lisa, Hannah and Catherine, also discussed using their individual therapy sessions as a support to cope with the upcoming ending; *"I guess if you kinda reach out to them they'll be able to help you."* (Lisa, 3,82-83). The implication here is that if she engages in avoidant coping strategies the programme cannot support her with the ending.

3. Experiencing the ending of DBT as a reparative process

The third theme represented participants' experience of going through the process of ending DBT as reparative. There was a sense from participants that the process of ending DBT was a catalyst for change in terms of how they cope with endings and through the experiential process of ending DBT they recognise that endings are necessary for their own progression.

The impact on increased self-esteem and self-efficacy is highlighted by Hannah and how the experiential process of coping with an ending has been reparative in terms of increasing her self-belief; *"....massive effect erm yeah because like at one time in my life things endin' and me havin' to manage on me own an' cope of my own is like my worst ever fear and now like I say although the thought will come into my mind erm it's like a huge benefit havin' done DBT that I'd be able to cope with that feelin'"* (13,337-340). Maria described the transition from an external locus of control to an internal locus of control in relation to engaging with healthier coping mechanisms*; "... even though somebody really is there and they are sympathetic and they do understand, they are not doing the work for you. In the middle of the night if you have a terrible time it is you who is doing it and it is just understanding that it is actually you who is doing that, not other people…it is quite empowering"* (2,44-48). *In the middle of the night* conjures up a sense of being alone with no support and the ability to bring these moments to mind appears to improve self-confidence and self-efficacy. Lisa discussed the time lag between the end of her DBT programme and the start of the graduate group as providing an opportunity for self-development and assimilation of skills; *"I'm one of them people where things have to be like really organised and indirectly that kind of not having that order or organisation of it*

is like I have had to deal with that which that's something completely new for me…so like, like accidentally they've kinda been quite good in that sense" (4,88-92).

Catherine described how the experiential process of having coped with ending DBT has given her a sense of optimism about future endings and changed her expectations; *"Havin' a good one…knowin' that it was possible to have a good endin'…an' not just expectin' it always to be bad"* (11,294-295). She also discussed how having a sense of being able to cope with endings has given her *"more confidence to, to try things and to actually build relationships with people, like I've doubled the number of friends that I've got which is great…because I'm not scared of them disappearin' an' movin' off to somewhere else an' me bein' left behind so yeah kinda given me more of a life, like a social life an' it's great fun"* (12,307-311). Lorraine also highlighted the transition from endings provoking feelings of fear and apprehension to providing her with the self-confidence to create new opportunities for herself; *"I think I'm not afraid of starting things, that's the difference, I'm not afraid of engaging in things"* (23,640-641).

The idea that endings provide access to new opportunities was a sentiment that was shared across the participants. Maria highlighted the difference between using avoidance as a coping mechanism and being open to new experiences; *"because if I avoided endings, endings are a natural part of life, everything happens, there is always an end and if you avoid it then you are not going to start anything either. So if you don't start anything you are never going to experience anything new or anything good so you can't hide so you might as well just give up."* (12,329-332). There is a sense that embracing endings is embracing life itself. Hannah also shared this sentiment in relation to being able to accept and manage endings and *"enjoy then the next chapter kind of thing"* (14-270-271).

4. Personal growth during the DBT programme resulting in a sense of enhanced resilience for the future

The fourth theme represents participants' personal growth resulting in a sense of enhanced resilience for the future. This growth appeared to arise through the relational experiences of DBT, through reflecting on their own personal journeys, the internalisation of DBT skills and their journey of recovery.

Participants described relational experiences that illustrated the impact of these on their sense of self-efficacy. Participants indicated trust in their therapeutic relationships as enabling change. Maria described how the therapists *"have just spent six months with you while you poured your heart out of course they know that you are bothered about it but they clearly don't think that you are any kind of a risk so you should believe that"* (6,148-150). This illustrated empathy on the part of the therapist in terms of understanding how fearful participants are in relation to the end but also supporting participants to end as planned. Trusting others is a new experience for participants, which demonstrates self-development. Participants also illustrated personal growth through interpersonal relationships external to DBT. Catherine described how she supported a friend with a recent transition; *"it's almost like I'm her mindfulness champion or somethin' (laugh) (sniff) an' I catch myself every now an' again thinkin' yeah you really sound like your DBT therapist there…"* (10,271-273). Catherine, along with other participants, demonstrated a self-awareness that her own discourse had changed and that she had engaged in a process of internalising her therapist's reflections. Lorraine also discussed how her skills have become so *"embedded in my day-to-day routines"* that this has resulted in her passing her knowledge onto her friends *"even my friends now are practicing a little mindfulness"* (8,197-198). The idea of teaching others and being in a position to impart knowledge appears to have enhanced self-esteem and self-efficacy.

Participants used temporal comparisons to reflect on their own journeys and to illustrate growth and personal development. Hannah also used a temporal comparison to highlight her self-development; *"I knew it had made like a massive difference because erm like for me self-harm was a major part of my life and erm I spent years, well since the age of 10 up until 29, hurtin' myself many a times, I wouldn't even go a week in-between hurtin' myself erm and now I haven't hurt myself for well over a year"* (1,120-123). Temporal comparisons illustrated the change in the intensity and frequency of maladaptive coping patterns and interpersonal interactions provided tangible examples to illustrate their growth and development. Participants also used social comparisons to highlight their self-development and increased self-awareness. Maria stated; *"it makes me feel really strong, it makes me feel really privileged because when I talk to other people in my everyday life, I realise just how much people have absolutely no understanding of themselves and their emotions and how simple things*

effect them and these are everyday people" (5,119-122). *Everyday people* are people who do not experience mental health difficulties so this is a normalisation process for her in relation to her lack of self-awareness in the past but also her increase in self-efficacy. Engaging in social comparisons supports her enhanced sense of resilience.

Participants also demonstrated that the internalisation of DBT skills has provided them with alternative coping mechanisms. Lorraine described; *"even in the six months since it ended, I have made progress…even though I have had my ups and downs, I did, I got an urge to self-harm but I managed it, you know, and that, that came clearly to me when I got through it. Was like, yea (high tone), I have moved on. That is not, it is not my only way of coping and it is not a way of coping I would chose, so yea, that is positive"* (26,699-704). This excerpt shows that she still experiences urges but that she now feels that she has a *choice* in how she responds to those. Her use of the word *even* also conveys that she has an understanding that six months is not a long recovery period but despite that she has recognised her own self-development and an enhanced resilience for the future. Lorraine's use of a high vocal tone to say *yea* indicates that, for her, this progress is something to celebrate. Participants also remarked that others have noticed changes in how they interact indicating improved interpersonal effectiveness. Frances remarked that her niece stated; *"'you're so different' she goes 'it's so easy to talk to you now' and that meant the world, and I'm like 'yeah that's what DBT's done to me' so I can like prepare myself for situations now before I go into them so I've not got expectations out of those situations, but yeah, it's changed my life drastically…"* (3,73-77).

Hannah described how when it came to the end of DBT she *"realised just how much I'd taken in and taken on board and how much I was actually usin' in my own life completely outside of DBT… I knew it was makin' err like a vast difference to my life"* (6,140-145). The internalisation and generalisation of skill use across situations appears to have provided participants with an awareness of enhanced resilience for the future and alternative coping mechanisms. Catherine also highlighted this internalisation and generalisation; *"I think havin', havin' skills an' (pause) knowin' which skills to use an' knowin' erm (pause) knowin' how to take a step back an' an' look at things a bit differently"* (5,112-113).

Lisa described struggling with external motivation during the programme "*on the days where I couldn't do it for myself I'd then do it for her"* (5,124) the impact of which was more challenging post DBT. Lorraine described how *"all your healing is not going to happen here"* (16,422) which demonstrated insight into recovery being a journey that takes place after the completion of the programme. The understanding of recovery being an on-going journey was mirrored across the participants with them verbalising that learning, internalising and generalising skills and fighting urges to self-harm was an on-going process.

Discussion

The aim of this study is to explore participants' experiences of ending DBT and how this experience has influenced their perception of previous endings and management of future endings. Data gathered from semi-structured interviews with six participants were analysed and four key themes were identified. What emerged from these themes was that the experiential process of ending DBT was reparative and that this experience was more powerful than the knowledge of having the skills to cope with the ending in advance. Participants experienced fear in anticipation of the ending based on their previous experiences while also engaging in the therapeutic structure of DBT. It was only with the benefit of hindsight that participants recognised that the skills they learnt on the programme, along with the DBT structure and processes, supported them to cope with the ending. On completion of the programme participants recognised their own self-development, especially in relation to managing the ending and demonstrated an awareness of enhanced resilience for the future as a result. Participants openly discussed previous endings in their lives in relation to feeling abandoned, rejected and out of control and they discussed their skills deficit in relation to how they coped previously. While still engaged with the DBT programme, they were fearful of the ending because they were not expecting it to differ from their previous endings, with some participants fearing a relapse. It was not until the experiential process of ending DBT they realised that their ability to cope had changed, they had a new skill set and that the circumstances around endings could be different. This positive ending experience, although not without its challenges, has provided

participants with a reparative experience that has reduced their fear of endings and resulted in them reframing how they believe they can and will cope with endings in the future.

The themes that have emerged from the participants' experiences of ending DBT reflect the therapeutic process. This finding is line with Ticho's (1971) stages of termination and Fragkiadaki and Strauss's (2012) grounded theory research on therapists' experiences of termination. It is interesting that while the research was conducted within different therapeutic models, both service users and therapists experience a termination process. While this helps to normalise the termination experience for clients there are a few key differences between the two processes that highlights the struggle with endings that those with BF typically experience. From an attachment perspective both therapists and clients will approach the termination stage with expectations and fantasies about what it means to be separated (Holmes, 1997) and the emotions triggered will largely be based on their previous experiences of endings, transitions and loss. The end of therapy is a period during which the therapist and client must transition from working together to going their separate ways (Gutheil, 1993), a transition that is made easier if a secure base has been established (Holmes, 1997).

The first theme focussed on the fear evoked in anticipation of the ending and during the ending process. All of the participants identified with this emotion which appeared to arise out of their previous experiences of endings. This was mirrored in Fragkiadaki and Strauss's (2012) research that highlighted therapists' history of loss as having an important influence on therapy termination. In the current study, participants had a damaged sense of self-efficacy and had learnt maladaptive coping strategies based on their previous experiences of endings. This is supported by Hudgins' (2013) finding that participants, based on previous experiences, felt rejection and anxiety about their future in response to the termination of a music therapy group. Other research has also identified negative emotions that are commonly associated with endings such as grief, loss, sadness and anxiety (Gelso & Woodhouse, 2002; Kramer, 1986; Roe et al., 2006b). Individuals with BF are commonly found to have comorbid anxiety and mood disorders (Zanarini et al., 2008) so it would not be uncommon for them to experience intolerance of uncertainty (Dugas & Ladoucer, 2000) to a greater or lesser degree which would increase their levels of fear and anxiety in relation to therapy termination and their uncertainty about coping on their own. While fear and anxiety were identified in the current study,

feelings of loss and sadness were not. Sensitivity to real or perceived abandonment is a common experience for those with BF, which is often accompanied with intolerance of aloneness (Gunderson, 1996). Therapeutic interventions, such as DBT, can be effective in supporting clients to change maladaptive behavioural responses to separations and endings within 12 months, however, traits related to fear of abandonment were found to be the most persistent and enduring characteristics in people with BF (Zanarini et al., 2007). Gunderson (1996) argues that repairing the psychological deficits that underlie the behaviours requires more time which may explain why fear was the emotion activated for the participants in this study as it was likely to be triggered by a fear of abandonment from their past.

While fear of having to cope alone emerged as an across-participant superordinate theme only one participant, Frances, mentioned transitional objects, for example her DBT file and diary sheets, which serve as a memory aid. Transitional objects are often seen as an extension of the therapist and can provide comfort and support when the therapist is unavailable (Gunderson, 1996). However, people, such as a substitute therapist or support groups, can also be experienced as transitional objects to reduce trauma caused by separation. Lorriane, discussed building up supports outside of both DBT and mental health settings with the end of the programme in mind and Hannah identified ongoing support from her care co-ordinator after DBT. In a study related to dropout from DBT, Gaglia et al. (2013) found that a history of care coordination was the only variable significantly correlated with drop-out from the programme. While Hannah did not drop-out of therapy, she completed after six months so it seems that availability of care-coordinators as a support post DBT may impact on engagement and on the experience of ending.

The second theme is focussed on participants' engagement with the therapeutic structure of DBT to manage the ending. This theme identified the role of preparation and boundaries in working towards a planned ending and the interaction between participants and the processes and structure of the DBT programme. The existing literature on therapy terminations recognises that each therapeutic orientation will plan for the end of therapy in a different way and that it is the structure that determines the experience of the end (Mander, 2000). In the current research there was consistency across the accounts in relation to knowing that it was a time limited therapy, beginning with the end in

mind and working towards a planned ending. Preparing for the end of therapy is also recognised in the literature as being a containing process, for example, service users who had a positive termination experience had discussed termination in advance with their therapist (Knox et al., 2011). Crawford et al. (2007) found that transparency and preparation were especially important for service users with FPD. This finding is supported by the current study which illustrates the importance of preparation in working towards endings and transitions. Tapering of individual sessions is common practice in DBT as it helps to prevent service users experiencing the endings as abrupt (Seager, 2013) and it supports them to increase their autonomy by reducing dependence on the therapist (Baum, 2005). Other rituals such as gift giving (Yalom, 2005) can also help to prepare clients for the end of therapy. Lorraine mentioned this as part of her preparatory process but while Frances mentioned it after the interview, she did not mention it during it.

The relationship between length of treatment and quality of termination as experienced by the client is unclear (Marx & Gelso, 1987). Joyce et al. (2007) argued that studies with shorter termination reported more positive terminations due to the relationship between the therapist and the client being less intimate while Cobb (2006) argued that clients were less satisfied with terminations from shorter therapies because thy had not achieved their goals. That said many of the evidenced based therapies for BF provide therapists with guidance on managing endings since it is well established that this population struggle with therapy termination. Mentalisation based treatment (MBT; Bateman & Fonagy, 2008) advises therapists to focus on the feelings of loss associated with ending treatment, on the therapeutic gains and to discuss a follow-up programme. Cognitive-analytic therapy (CAT; Ryle & Kerr, 2002) works to a predetermined time limit, usually 16-24 weeks, and therefore advises therapists to count down the number of session and to exchange goodbye letters with clients in preparation for the end and to discuss a follow-up session three months later. Goodbye letters offer an accurate account of what has been achieved during therapy, identifies where further work is needed and acknowledges disappointment despite the gains that have been made. The aim of the letter is to act as transitional object and to support the internalisation of the experience (Ryle & Kerr, 2002). Unpublished research into client's experiences of ending CAT also found that participants experienced endings as new beginnings (Lydon, 2014) which supports the finding of the

current study. In inpatient settings, Crawford (2004) highlighted the importance of discharge planning which includes carefully planning for transitions and endings in advance with clients. Working within an attachment model including graded discharge, arranging ongoing support and where possible discharging in to the care of an attachment figure to reduce the risk or self-harm suicide (Bucci et al., 2015). A study investigating the process of recovery in The Haven, a therapeutic community and crisis house, focussing on the experiences of service users and carers, found that participants dreaded losing their secure attachment and sense of home in The Haven if they recovered (Castillo et al., 2013). Castillo et al. (2013) hypothesised that recovery would become synonymous with the idea of loss and the pursuit of recovery could lead to the withdrawal of, what they described as "crucial support" (p.272). This resulted in the development of a new model of recovery, namely transitional recovery which meant that recovery would not be penalised with withdrawal of services but rewarded with continued support. They reported that this would result in less use of the service over time but with the option to remain engaged, however they did not detail how that would be achieved (Castillo et al., 2013). The different therapeutic models, MBT, CAT, therapeutic communities and DBT all prepare for and work towards the end of therapy. There are, however, differences in how they manage the end, most notably the offer of some sort of follow-up. Some DBT programmes do routinely offer a graduate group however these seem to be conceptualised differently than follow-up sessions or contact with the individual therapist. Some DBT programmes also offer continued phone coaching as long as the person is using skills. The aim of this is to prevent punishing recovery. This, however, was not offered to the participants in this study and Frances discussed how she would find it helpful to know that someone was available. It might also support those who are more externally motivated. The current study found that the experiential ending in DBT provided a catalyst for change so it would be interesting to know how endings differed for people who have on-going follow-up sessions or phone coaching available to them.

In the current research, the third theme suggests that experiencing the ending of DBT was a reparative process for participants. Ending DBT was experienced as a catalyst for change and the ending in itself was recognised as a necessary part of progression. In the literature on therapy terminations, supporting service users to experience a corrective emotional experience in relation to

endings is seen as an important element of the therapeutic process (Mander, 2000; Marx & Gelso, 1987). Participants need time to process the feeling of fear in relation to the ending which may have been in relation to fear of abandonment or intolerance of aloneness (Gunderson, 2006) and to draw on their new coping skills to manage this. The literature also emphasises therapeutic terminations as an opportunity for transformation, which was very much mirrored in this research as life after DBT was conceptualised as *a new beginning* and *a new chapter*. For the ending to be experienced as reparative clients need time to draw upon images and memories of the therapeutic programme to problem solve and gain confidence after termination. Through this process they are engaging with their new internal working model (Farber et al., 1995) to cope in a different way.

The fourth theme related to personal growth resulting in an awareness of enhanced resilience for the future. Participants noticed that through reflecting on their own journey they had improved self-efficacy through relational experiences and the internalisation of DBT skills. Participants also recognised recovery as an on-going process and had realistic expectations in relation to this. Katsakou et al. (2012) explored views of recovery within a population demonstrating BF and found that it was seen as a fluctuating process that included periods of improvement and periods where life was experienced as more challenging with the absence of difficulties seen as an on-going but distant goal.

Positive emotions such as a sense of accomplishment, pride, maturing, independence and self-respect expressed by the participants in relation to completing therapy mirror those found in the literature (Baum, 2005; Fortune, 1987; Knox et al., 2011; Marx & Gelso, 1987; Roe et al., 2006b; Zilberstein, 2008). Regarding participants' emotional experiences of the termination of DBT, this was, for many of them a process that surpassed the actual ending itself. This appears to be a common experience and Greenberg (2002) stated that emotions associated with the termination continue through the post-termination stage. It is likely that participants also experienced varied emotions due to the ending also representing *a beginning.* This may have introduced emotions associated with beginnings such as anxiety and pride (Fortune, 1897).

Quintana (1993) introduced the concept that service user transformation occurs through focussing on progress and their internalisation of the therapeutic processes. A good therapeutic relationship supports internalisation through continuing the therapeutic dialogue internally (Bellows,

2007). This internalisation of the therapist's voice was evident among the participants with two of them describing how they have noticed sounding like their therapist both internally and towards others. Wachtel (2002) introduced a relational theory regarding the therapeutic process which put forward the idea that loss and pain in life can be lessened through intimate contact with another human, namely the therapist. He rejected the notion of follow-up sessions or doing anything to reduce the impact of loss in relation to the termination of therapy. Wachtel (2002) argued that the client could engage with their new skills to find ways of reducing the pain and find compassion and caring through relational intimacy.

Based on the current research it seems that while it is important to highlight service user progress, their experiential process of overcoming, internalising the therapy and coping with the endings which was an event that they would previously have experienced as a trigger for relapse was the most powerful transformational experience. The DBT programme provided a therapeutic model whereby they had the opportunity and support to internalise and generalise DBT processes and skills. Through the experiential process of ending, participants realised the enormity of what they had achieved and this in turn increased their self-confidence, self-belief and self-efficacy.

Theoretical implications

This study contributes to psychological theory in a number of different areas. Attachment theory has been discussed in relation to the four themes and the study has illustrated how emotions triggered in anticipation of the ending of DBT were based on the internal working models of the individuals. This study illustrated how the development of a secure base within DBT and the use of transitional objects supported participants with the ending and supported them to develop alternative internal working models afterwards. Cognitive theorists propose that individuals experience psychological difficulties due to the meanings they give to events, filtered through the framework of core beliefs and assumptions which they have already developed through life experience (Beck, 1995). In this study, participants described being fearful of the ending based on their previous experiences of endings. According to cognitive theory, the only way to overcome fear is to face it, to

test if one's predictions are founded. In essence, the ending of DBT served as a behavioural experiment whereby the participants were exposed to ending DBT and this experience exposed them to their fear of ending and taught them that they can cope in a different way. Behavioural experiments are described as powerful because they impact on both implicational and propositional (verbal/logical) systems. This is based on Teasdale's interacting cognitive subsystems (ICS) model (Teasdale, 1997). The emotional qualities of behavioural experiments impact at an implicational level, which develops alternative schematic models, which then encompass changes in behavioural, cognitive, emotional and physical responses. Therefore exposure to the ending has provided participants with an opportunity for existing maladaptive cognitions to be disconfirmed which can provide evidence for new more adaptive cognitions (Bennett-Levy, 2004).

Clinical implications and further research

An important clinical implication of the current study is the importance of preparation and planning when supporting service users with FPD in working towards an ending or a transition. This supports Crawford et al.'s (2007) research that highlighted a clear need for encouragement and planning in relation to endings.

One superordinate theme that was evident among four participants was blurred boundaries in relation to ending DBT as a result of the graduate group, however, this theme was discarded as it did not emerge as dominant across participants. That said, it might have important clinical implications. The graduate group was available to attend, either, in conjunction to the tapered sessions of individual therapy towards the end of their DBT programme, or, after they had completed the full programme. The blurred boundaries were discussed in relation to the impact on their experiences of ending DBT. Research by Crawford et al. (2007) found that service users were concerned that the end of a therapeutic programme meant they would be denied all access to mental health services and this was a sentiment shared by some of the participants in this study. Crawford et al. (2007) noticed that this appeared to result in the development of 'step-down' programmes allowing continued access to less intensive components of a service. It seems that graduate groups are an attempt to provide service

users with on-going support based on an attempt to be person-centred and provide service users with services that they are requesting. While it is very important that service users' opinions are heard, it is also important to question whether this desire for on-going services is a reaction to the fear and anxiety experienced by an upcoming ending or if, in fact, they need further support. Furthermore, research on therapists' experiences of therapy termination has found that they too experience anxiety and that this is focused on questioning the client's ability to function without treatment (Fortune, 1987).

Prolonging therapeutic programmes and extending participants' number of sessions and particularly offering step-down services, for example a graduate group, is an area that needs further research. All services need to question if they are responding to the services users and/or the therapists' anxieties in relation to termination of therapy or if a clinical need for on-going support has been identified. If services are responding to anxiety rather than a clinical need, they are depriving service users of the experiential reparative process of an ending. Therapists and services as a whole must trust that service users can manage after the end of a therapeutic programme (Kramer, 1986; Ticho, 1971) and if programmes like DBT are preparing service users for a life worth living then they need to let service users live that life. Future research needs to (1) compare graduate groups versus no graduate groups in relation to participants managing the termination of DBT and (2) compare experiences of endings across range of therapies for people with BF, for example, MBT, CAT, DBT and therapeutic communities.

Current research found that the main emotion in anticipation of the ending was fear, however, other research has found emotions such as grief and sadness. This paper has outlined hypotheses in relation to why fear might be dominant within a population of people with BF but research is needed to explore this further. Some of the participants indicated that their experience of the skills group was akin to a course rather than an exploratry therapeutic group and that interpersonal relationships with other group members were discouraged outside of the programme. Does the structure of DBT mediate against feelings of grief and sadness? Or is there another mediating factor?

Strengths and limitations

This is the first IPA study to explore the experiences of ending DBT as described by completers of the programme. There have been a number of studies that explored participants' experiences of DBT however none of these focussed specifically on their experiences of ending. This study has captured how participants have made sense of their experiences and as a result has made an important contribution to understanding DBT endings in clinical practice. The aim of IPA is to illustrate, inform and master themes and this research has demonstrated this by firmly anchoring findings in direct quotes from participant accounts as recommended by Smith et al. (2009).

There are, however, some limitations to this study that need to be considered. Firstly, the small sample size and the idiographic nature of IPA studies mean broad generalisations in relation to the findings are not possible. However, the findings could influence and contribute to the theory in this area (Smith et al., 2009). Secondly, only female participants took part in this study and while this increases the homogeneity of the research it must be noted that the experiences of DBT terminations may differ for males. Thirdly, the length of time between ending DBT and being interviewed for this research differed from 1 week to 11 months, and they were undoubtedly at different stages of processing the ending. The participant who ended one-week prior would have had less time for reflection. Finally, keeping in mind safety and convenience for participants the interviews took place at NHS premises of the participants' choice. During the scheduling of interviews, it came to the researcher's attention that some participants had a preference for not being interviewed at the location of their DBT programme and requested for the interview to take place at NHS premises elsewhere. Participants who did not make such a request often commented on the process of returning to the DBT location, implying that it was an emotive experience for them. Another participant commented that she felt tongue-tied once the Dictaphone was turned on and she was notably more talkative after the interview. It is therefore likely that contextual aspects of the interview such as the location and the recording of the interview may have impacted on participants' accounts.

Conclusion

It is well documented that there are high levels of insecure attachment in people with BF. The literature has focussed on the role of therapists and services in general to provide corrective emotional experiences that challenge and modify people's insecure internal working models (Bucci et al., 2015). The themes identified in this research illustrate the impact of insecure attachment styles on participants' experience of ending DBT. The themes also illustrate how the processes and structure of DBT provide a corrective emotional experience which allows participants to experience a new opportunity for success and self-efficacy.

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Appendix A

Theoretical contributions

IPA is a qualitative research approach focused on the exploration of participants lived experience and how participants make sense of these experiences (Smith, 2004). It is phenomenological in its interest in participants' perceptions of objects or events and in their orientation towards the world (Smith, 2004). Its interpretative component contextualises these perceptions within their cultural and physical environments and within their constructed relationship to the world through a psychological framework (Larkin, Watts & Clifton, 2006). IPA is also concerned with the researcher making sense of or interpreting the participants' experiences given that human research involves a double hermeneutic, whereby "the participant is trying to make sense of their personal and social world while the researcher is trying to make sense of the participant trying to make sense of their personal and social world" (Smith, 2004, p40). The hermeneutic circle which refers to the active relationship between the whole and the parts is the key to this theory and emphasises the researchers relationship to the data as shifting according to the hermeneutic circle (Smith Flower & Larkin, 2009).

The three core tenets of IPA are that it is idiographic, inductive and interrogative. IPA is committed to idiographic inquiry where each case is thoroughly examined as a whole before moving onto the next case and eventually conducting analysis across cases for convergence and divergence (Smith, 2004). It is argued that exploring deeper into one person's experience provides a better understanding of the universal experience and that it provides intricate analyses of the phenomenon under investigation (Smith, 2004). IPA is inductive in that it adopts a bottom-up approach and moves from specific observations to broader generalisations and theories (Smith et al., 2009). The results of IPA question and/or promote existing psychological literature and as a result it is acknowledged as an interrogative approach.

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Appendix B

Rationale and choice of method

At the outset of this research, consideration was given to a range of qualitative methodologies but they were rejected in favour or IPA for the reasons outlined below. Grounded theory is generally employed to generate a theoretical-level account of a phenomenon however this was not in line with the objectives for this research. Discourse analysis is often used to "explore the regulatory and constructive function of language and practices" (Smith, Flowers & Larkin, 2009, p.44) or within ethnomethodological tradition it is understood to refer to a "communicative interaction" (Smith et al., 2009, p.44). This would be an appropriate methodology if the focus of the research was on how people make use of cultural resources in verbal interactions and the function of language in a specific context. Another methodological option was narrative analysis which is either interested in the content of people's stories or the structure of people's stories (Smith et al., 2009). Narrative analysis shares some commonalities with IPA and some commonalities with discourse analysis (Smith et al., 2009). It was felt that for the purpose of exploring participants' experiences of ending dialectical behavioural therapy, IPA as a phenomenological approach was the most suitable methodology. IPA allowed the researcher to develop an understanding of the participants in context and to develop an interpretive account of their experiences which is in line with the aims and objectives of the study (Larkin et al., 2006).

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